# FACTORS THAT CONTRIBUTE TO HIGH HIV INCIDENCE AMONG ADOLESCENT GIRLS AND YOUNG WOMEN IN ZIMBABWE:

## THE CASE OF MATABELELAND SOUTH

NATIONAL AIDS COUNCIL ZIMBABWE

UN WOMEN

FINAL REPORT

# ACKNOWLEDGEMENTS

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# ACRONYMS

| | |
|---|---|
| **HIV** | Human Immunodeficiency Virus |
| **AGYW** | Adolescent Girls and Young Women |
| **ZIMPHIA** | Zimbabwe Population-based HIV Impact Assessment |
| **NAC** | National AIDS Council |
| **DREAMS** | Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe |
| **CPMM** | Convergent Parallel Mixed Methods |
| **CAPI** | Computer-Assisted Personal Interview |
| **MRCZ** | Medical Research Council of Zimbabwe |
| **SPSS** | Statistical Package for the Social Sciences |
| **NGOs** | Non-Governmental Organizations |
| **CSOs** | Civil Society Organizations |
| **CDC** | Centres for Disease Control and Prevention |
| **SRH** | Sexual and Reproductive Health |
| **CAMFED** | Campaign for Female Education |
| **OPHID** | Organization for Public Health Interventions and Development |
| **UNAIDS** | Joint United Nations Programme on HIV/AIDS |
| **CBOs** | Community-based Organizations |
| **CSO** | Civil Society Organisation |
| **KII** | Key Informant Interview |
| **RDC** | Rural District Council |

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# EXECUTIVE SUMMARY

## Introduction

UN Women Zimbabwe and the National AIDS Council (NAC) collaborated on a study to understand the high HIV incidence among adolescent girls and young women (AGYW) in Zimbabwe, particularly in Matabeleland South. The province has consistently recorded high HIV prevalence rates, making it a critical area for addressing the HIV epidemic. Matabeleland South shares borders with South Africa and Botswana, significant transit points for population movements. This report highlights the unique drivers of HIV infections in Mangwe, Bulilima, Beitbridge, Matobo, Insiza, Umzingwane and Gwanda districts of Matabeleland South.

## Purpose and Objectives

The study sought to comprehensively assess factors driving the high HIV incidence among AGYW in Zimbabwe, with a particular focus on Matabeleland South due to its disproportionately high HIV prevalence. The findings from the study aim to inform HIV response efforts by addressing the specific challenges faced by AGYW in the province, thereby contributing to the reduction of HIV incidence in the province. The research questions delve into the various dimensions of the problem, including social, behavioral, economic, and cultural factors influencing HIV incidence among AGYW in Matabeleland South. Additionally, the study identified barriers to accessing HIV prevention, testing, and treatment services, assess existing programs targeting AGYW, pinpoint gaps in these programs, and offer recommendations for effective HIV prevention programming tailored to AGYW in the province.

## Scope

The study covered all seven districts in Matabeleland South, with focused field visits conducted in Mangwe, Bulilima, Matobo, and Beitbridge. It encompassed both rural and urban settings and targeted various groups, including AGYW, adolescent boys, young men, sex workers, and other vulnerable populations such as people living with disabilities, key populations individuals, orphans, and vulnerable children.

## Methodology

Employing a Convergent Parallel Mixed Methods (CPMM) design, the study integrated quantitative and qualitative data collection methods to explore the research questions comprehensively. The study was guided by the Gender Responsive Framework and human rights-based approach to ensure respecting participant's rights and dignity. Data collection involved a thorough desk review of relevant literature and 23 key informant interviews with key stakeholders from various organizations and government entities. 32 focus group discussions were conducted to gather insights from diverse perspectives, including adolescents and youth, sex workers, and key populations individuals. Furthermore, 415 respondents from the quantitative data were collected through a survey questionnaire administered electronically using the computer-assisted personal interviewing (CAPI) technique, ensuring inclusivity and representation across all target groups and districts. The study adhered to ethical guidelines set by the Medical Research Council of Zimbabwe (MRCZ), ensuring participants' protection, confidentiality, anonymity, and informed consent. Measures were taken to include all

individuals irrespective of their health status, disability, or socio-economic background, promoting non-discriminatory participation and upholding ethical standards throughout the research process.

## Findings

The HIV incidence among adolescent girls and young women (AGYW) in Matabeleland South province was found to be higher than the national incidence rate in Zimbabwe. The incidence rates range from 0.2 to 1.1 across all districts, with higher rates observed among young women than adolescent girls in 2023. Mangwe and Bulilima districts were found to have the highest incidence rates among AGYW. The number of new HIV infections was higher among young women than adolescent girls, with Gwanda and Insiza districts having the highest number of new infections. However, there has been a decreasing trend in new HIV infections among adolescents and young women over the years (2019 - 2023). The rate of decrease has slowed down in the last two years, indicating the need for interventions to address the contributing factors and prevent a potential increase in HIV incidence among AGYW.

### Factors Contributing to High HIV Incidence Among AGYW in Matabeleland South

The study identified several key factors that cause high HIV incidence among AGYW, including limited HIV information and knowledge, engagement in sex work, transactional and intergenerational sex, gender inequality, negative role models, limited economic empowerment, and multiple concurrent sexual partners. These factors create a complex vulnerability that perpetuates inequity and increases the risk of HIV transmission. The research highlights the lack of accurate knowledge among AGYW regarding HIV prevention methods, transmission modes, and treatment, which leads to risky behaviors. It also emphasizes the low-risk perception among the AGYW, fueled by misconceptions about circumcision and a belief that HIV only affects older individuals. Poverty and limited economic empowerment were identified as significant contributors to the high HIV incidence, as AGYW may engage in unprotected sex for financial benefits.

### Barriers to accessing HIV prevention, testing, and treatment services.

The study explores persistent barriers to accessing HIV prevention, testing, and treatment services for AGYW in Matabeleland South. Despite increased service availability, challenges such as unfriendly healthcare workers, lack of confidentiality, and fear of judgment deter AGYW from seeking services until they are critically ill. Disparities in service utilization across districts reflect concerns over privacy and judgment, exacerbated by societal norms denying AGYW's sexual activity. Breaches in privacy, color-coded cards that disclose the high or low viral load of HIV-positive patients, and the absence of youth-friendly services further discourage service uptake, leading to alternative healthcare-seeking behaviors particularly among AGYW, through various development initiatives led by organizations like the DREAMS(Determined, Resilient, Empowered, AIDS-free, Mentored and Safe). Gender inequality, rooted in patriarchal norms and gender-based violence, exacerbates HIV risks, while societal stigma towards key populations individuals limits access to services. Complex webs of sexual relationships, secrecy, and societal expectations fuel HIV transmission, highlighting the need for targeted interventions addressing structural, social, and cultural factors to enhance service accessibility and mitigate transmission risks among AGYW.

### HIV programs

HIV prevention programs in Matabeleland South province aim to curb HIV transmission, particularly among AGYW, through various development initiatives led by organizations like the DREAMS

consortium, Zimbabwe Health Intervention, and others. Despite these efforts, HIV infections persist among AGYW due to challenges, such as ineffective program targeting and limited male inclusion in interventions. Programs primarily focus on AGYW, neglecting adolescent boys and young men, who contribute significantly to HIV transmission through intergenerational and transactional sex. Moreover, societal norms rooted in gender inequality hinder AGYW's ability to negotiate safe sex and access sexual and reproductive health services. Siloed programming, insufficient comprehensive sexuality education, and cultural practices further exacerbate HIV risks, particularly for minors below the legal age of consent, who are sexually active but lack access to HIV information and prevention services. Addressing structural barriers, integrating HIV into sexual and reproductive health programs, and challenging harmful gender norms are crucial for effectively reducing HIV incidence among AGYW in Matabeleland South.

## Conclusion

In conclusion, the factors that contribute to high HIV incidence among AGYW shed light on the complex landscape of HIV prevention and treatment efforts in Matabeleland South. These HIV risk factors constitute a complex web of sexual relationships which increase HIV incidence not only among AGYW but among the provincial population at large. These challenges are deeply intertwined with cultural, socio-economic, and gender-related factors, which underscore the need for a multifaceted and holistic approach to combating the HIV epidemic in the province.

The barriers to accessing HIV testing services, such as geographical distances, lack of privacy, and fear of stigma, highlight the importance of addressing structural and systemic issues that impede access to HIV services. Additionally, gender inequality and sexual gender-based violence (SGBV) exacerbate the vulnerability of AGYW to HIV infection, emphasizing the necessity of addressing power imbalances and harmful cultural practices that perpetuate these inequalities. Furthermore, the exclusion of adolescent boys and young men from targeted interventions, along with fragmented approaches and ineffective targeting, aggravate vulnerabilities among AGYW. The lack of integration between HIV programming and Sexual and Reproductive Health and Rights (SRHR) perpetuates stigma and discrimination, further impeding access to essential services. Addressing these systemic issues is critical for achieving meaningful progress in reducing HIV incidence in the province.

Therefore, the intricate interplay of numerous factors contributing to high HIV incidence among AGYW underscores the urgent need for comprehensive, context-specific approaches to HIV prevention and treatment in Matabeleland South. Overcoming the structural, cultural, and gender-related barriers to accessing HIV services is essential for achieving sustainable progress in reducing HIV incidence and improving the health and well-being of all individuals in the province. Understanding and addressing these complexities is vital for shaping effective strategies that can make a lasting impact on the HIV epidemic in Matabeleland South.

## Recommendations

Establish Social Safety Nets for AGYW from underprivileged families through the provision of conditional cash transfers that can be instrumental in helping AGYW meet their basic needs and reduce their reliance on child or early marriage, transactional sex and/or sex work.

Strengthen the provision of vocational skills training opportunities to adolescent girls and young women to increase their earning potential and overall economic independence.

Design family-level income-generating activities to boost parents' financial capacity and provide holistic care for their children and youth.

Design and implement programmes that empower men and boys to understand SRH and HIV better and increase their related service uptake.

Foster partnerships with community-based organizations, traditional and religious leaders, and other stakeholders to challenge harmful gender norms and promote gender equality, as well as engage men and boys as allies in addressing SGBV and promoting positive masculinity.

Partner with youth-led organisations to expand HIV prevention services and reach vulnerable populations in Matabeleland South.

Provide a mix of edutainment including working with influential artists, to impart HIV information to young people.

Establish youth hubs/centres that allow for supportive community environments that provide alternatives to negative role models and behaviours.

Develop and implement peer pressure strategies that promote positive peer influence against drug and substance abuse, including the establishment of positive peer networks early in adolescence.

As a follow-up to this study, conduct case studies on some of the emerging factors, e.g., artisanal miners and large population movements at border towns, to provide more information to programmers working to reduce HIV incidence amongst AGYW.

# 1 SECTION I. INTRODUCTION

UN Women and the National AIDS Council (NAC) commissioned a study on factors that contribute to high HIV incidence among adolescent girls and young women (AGYW) in Zimbabwe, with a focus on Matabeleland South province. This report presents the contextual background, including the context of the study. The report further outlines the methodological approach used in conducting the study, findings, conclusions, and recommendations.

## 1.1 Contextual Background

Matabeleland South is a province in southwestern Zimbabwe with a population of **760,345** as of the Zimbabwe Population and Housing Census (2022). The population distribution per district is presented in Table 1 below.

**Table 1:** Matabeleland Population

| Name of District | Population |
|---|---|
| Beitbridge Rural | 94,001 |
| Beitbridge Urban | 58,574 |
| Bulilima | 85,600 |
| Gwanda Rural | 124,548 |
| Gwanda Urban | 27,143 |
| Insiza | 122,903 |
| Mangwe Rural | 65,562 |
| Mangwe Urban (Plumtree) | 14,460 |
| Matobo | 95,694 |
| Umzingwane | 71,860 |
| **Total Population in Mat South** | **760,345** |

According to the latest statistics from the Zimbabwe Population Based HIV Impact Assessment (ZIMPHIA 2020), Matabeleland North and Matabeleland South provinces recorded the highest HIV prevalence rates in the country. Matabeleland South remains the hotspot for HIV and AIDS after recording the highest HIV prevalence rate of 22.3 per cent in 2020.[1] The province shares borders with South Africa and Botswana, with Beitbridge and Plumtree as entry points between the two countries. In 2021, the HIV incidence rate for Matabeleland South was 0.88 per cent. Although the HIV incidence reduced to 0.33 per cent in 2022, the province continues to have the highest HIV incidence in the whole country.[2] In 2023, the Zimbabwe HIV incidence rates for adolescent girls and young women were at 0.2 and 0.3 per cent, respectively. The incidence rate amongst adolescent boys was lower (0.01) than that of adolescent girls, and the HIV incidence rate for young men (0.13)

1 MOHCC; ZIMPHIA. 2020.

2 Ibid.

was also lower than that of young women.[3] The seven Matabeleland South districts (Gwanda, Insiza, Beitbridge, Matobo, Bulilima, Mangwe and Umzingwane) have their unique drivers of HIV infections.

The Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) (2021 – 2025) is the most current policy document that seeks to end AIDS as a public health threat and to achieve an AIDS-free generation in Zimbabwe.[4] The ZNASP emphasizes several strategic shifts to enhance the HIV response, including combining a mix of prevention approaches, integrating HIV services with other health programs, and empowering communities to actively participate in prevention and care. The strategy also focuses on addressing gender disparities, promoting human rights, and leveraging data and innovative approaches for better outcomes. The strategic plan aims to accelerate progress toward an AIDS-free Zimbabwe, emphasizing collaboration, innovation, and community engagement.

Gwanda, Umzingwane, Matobo and Insiza districts are characterized by artisanal miners who lure AGYW with money. A total of 456 instances of sexually transmitted infections (STIs) among adolescent girls and young women (AGYW) aged 10-24 in Gwanda were reported between January and August 2022. Out of these cases, 357 were girls, and 99 were boys.[5] Beitbridge is Zimbabwe's busiest port of entry, with high population movements and sex workers coming from as far as Mutoko and Victoria Falls. About 50 per cent of sex workers in Beitbridge are HIV positive.[6] A study by Siziba in 2022 revealed that the major contributors to the high STI incidence in Beitbridge were sex work, multiple sexual partners, none or inconsistent condom use during sexual intercourse, and excessive alcohol consumption.[7] These results suggest that risky sexual behaviors were indicators of high STI incidence in Beitbridge. In 2022, Bulilima district accounted for the province's highest incidence rate of 0.38 per cent, higher than the national average rate of 0.24 per cent in the same year.[8] Sexual exploitation of AGYW is rampant at the Plumtree border post, where intergenerational and transactional sex is common.[9] In Bulilima, migrant workers go to South Africa and Botswana, leaving AGYW to fend for themselves with no parental guidance and at risk of transactional sex.[10] Similarly, in Mangwe, the unprecedented scale and feminization of cross boarder labor migrants to South Africa makes AGYW vulnerable to HIV infections.[11]

## 1.2 Study Purpose and Objectives

The study provided an in-depth assessment of the factors contributing to the high HIV incidence among AGYW in Zimbabwe, focusing on Matabeleland South due to its high HIV incidence rate. Findings from this study will enable the UN Women country office and other stakeholders to inform the design and implementation of the national HIV response by addressing factors that contribute to high HIV incidence among AGYW in Matabeleland South Province.

## 1.3 Research Questions

- What factors (Social, Behavioural, Economic, Cultural, Biological, etc.) influence high HIV incidence among AGYW in Matabeleland South?

3 HIV Statistics 2023, NAC- UNAIDS

4 Zimbabwe National HIV And AIDS Strategic Plan (2021 – 2025). Accessed? https://www.nac.org.zw/wp-content/uploads/2022/02/ZIMBABWE-NATIONAL-HIV-STATEGIC-PLAN_2021-2025-1.pdf

5 Chronicle. 2022. "Gwanda STI Cases Rise as Girls, Young Women Bear the Brunt." Accessed? https://www.chronicle.co.zw/gwanda-sti-cases-rise-as-girls-young-women-bear-the-brunt/

6 Sunday News, June 2023.

7 Anelle Siziba et al. 2022. "Risk Factors Associated with a High Incidence of Sexually Transmitted Infections in Beitbridge, Zimbabwe." *Curationis* 25 (1), Pp. 1-5.

8 The Chronicle. 16 June 2022.

9 The Chronicle. 16 June 2022.

10 Ibid.

11 Maphosa F. 2011. "Labor Migration and HIV/AIDS: The Case of Mangwe District in Southern Zimbabwe." Humanities Review Journal 8(1).

- What barriers to access and utilization of HIV prevention, testing and treatment services by AGYW exist in Matabeleland South?
- Which programmes are available in Matabeleland South that are working to reduce HIV incidence among AGYW in the province?
- What are the gaps in programmes that address factors contributing to high HIV incidence among AGYW?
- What recommendations can be made for effective HIV prevention programming for AGYW in Matabeleland South?

### 1.4 **Scope**

The study covered all seven districts in Matabeleland South, with field visits conducted in four specific districts: Mangwe, Bulilima, Matobo, and Beitbridge. Primary data was collected in both rural and urban settings. The study focused on several target groups, including adolescent girls and young women (AGYW), adolescent boys and young men, sex workers, and other vulnerable groups such as people living with disabilities, key populations, orphans and vulnerable children in two age categories (15-19 and 20-24 years). Community leaders were also included in the study to ensure comprehensive data collection. Their involvement aimed to gather a holistic perspective on the contributing factors to the high HIV incidence among AGYW in Matabeleland South.

# 2 SECTION II. METHODOLOGICAL APPROACH

The methodology section describes the study design, data collection methods and sampling, data quality assurance measures, data analysis and reporting procedures.

## 2.1 Study Design and Conceptual Framework

A Convergent Parallel Mixed Methods (CPMM) study design was employed for this research. Quantitative and qualitative data were collected using the same variables related to the research questions. The study was guided by the Gender-responsive Framework, which focuses on HIV prevention and response and the importance of addressing gender inequalities as key drivers of HIV risk among girls and young women. Furthermore, the study adhered to a human rights-based approach to ensure the rights and dignity of the participants were respected. The key principles of this approach, including participation, accountability, empowerment, and non-discrimination, informed the research design, data collection process, and analysis.

## 2.2 Data Collection

The data collection phase involved pre-arrangements for field visits with support from the National AIDS Council and district-level partners. The following data collection methods and target data sources were utilized.

## 2.3 Qualitative Data Collection


**Desk Review:** Continuous review of relevant literature, including policy documents, national census documents, ZIMPHIA report, research publications, and the Matabeleland South provincial and district HIV estimates report (2023), was reviewed. The full list of reviewed documents is attached in Annex 3.


**Key Informant Interviews (KIIs):** In-depth face-to-face discussions with purposively selected key informants were conducted to gather data, opinions, and perspectives on factors contributing to high HIV incidence among AGYW in the districts. Open-ended interview guides and 23 key informant interviews were used, as presented in table 1 below.

**Table 2:** Key informant interviews

| | NGOs | Parastatal | Ministry | Duty bearers |
|---|---|---|---|---|
| | SAYWHAT | Insiza DAC | Ministry of Youth | Traditional Leader[12] |
| | Zimbabwe Institute of HIV Trust | Matobo DAC | | Councillor X 3 [13] |
| | ZNNP+ | Bulilima DAC | | |
| | Zimbabwe Health Intervention | Beitbridge DAC | | |
| | Zimbabwe Aids Network | Mangwe DAC | | |
| | Umzingwane Aids Network | Gwanda DAC | | |
| | Jointed Hands | Umzingwane DAC | | |
| | CESHHAR | ZPRC | | |
| | CAMFED | | | |
| | OPHID | | | |
| Sub Total | **10** | **8** | **1** | **4** |
| TOTAL | **23** | | | |

## 2.4 Focus Group Discussions

Sex and age disaggregated focus group discussions (FGDs) inclusive of persons with disabilities, key populations were conducted in the visited districts to gather data on factors contributing to high HIV incidence among AGYW. FGDs comprised 6-12 participants, moderated by a discussion facilitator with a note taker present. Participants were encouraged to express their views in their preferred languages. A total of 32 FGDs were conducted throughout the study, as summarized in Table 2 below.

**Table 3:** FGDs conducted.

| FGD with | Matobo | | Mangwe | | Beitbridge | | Bulilima |
|---|---|---|---|---|---|---|---|
| | Rural | Urban | Rural | Urban | Rural | Urban | Rural |
| Adolescent girls | √ | √ | √ | √ | √ | √ | √√ |
| Young women | √ | √ | √ | √ | √ | √ | √√ |
| Adolescent boys | √ | √ | √ | | √ | √ | √√ |
| Young men | √ | √ | √ | √ | √ | √ | √√ |
| Sex workers | | √ | | | | | |
| Sub Total | 4 | 5 | 4 | 3 | 4 | 4 | 8 |
| **Total** | | | | **32** | | | |

12 Matobo Rural.

13 Matobo Rural.

## 2.5 Quantitative Data Collection

### 2.5.1 Survey Questionnaire

A quantitative survey was administered using the computer-assisted personal interviewing (CAPI) technique. The structured questionnaire was programmed on smartphones and administered electronically using Kobo Toolbox, a real-time data collection application. The consultant digitized the questionnaire and closely monitored the data collection to ensure data quality.

**Sample size calculation**

In calculating the sample size for the survey questionnaire, the formula below was used:

$$n = \frac{Z^2 p(1-p)}{e^2}$$

where,
*n* = sample size for infinite population
*Z* = Z score
*P* = population proportion (Assumed as 50% or 0.5)
*e* = Margin of error

Given an infinite population, a sample size of 415 was calculated at a 96 per cent confidence level and a 5 per cent margin of error. This implies that for all the values calculated, one can be certain that of all reported values, percentage findings can either be a plus/ minus 5 per cent, and there is 95 per cent certainty that these figures are correct.

Of the target sample, 415 study participants were reached across all the districts visited. The purposive sampling technique was used to select the Beitbridge, Matobo, Bulilima and Mangwe districts due to their high HIV incidence rates. A simple random sampling technique was used to select the survey questionnaire respondents. To ensure inclusivity in the survey questionnaire, the mobilization of adolescents and young people was guided by an inclusion criterion that included OVCs, PWDs, key populations. Survey participants were equally distributed across all the districts, with 13 participants selected per district and per age group to give all adolescents and young people an equal opportunity to participate in the study, as illustrated in Table 2 below.

**Table 4:** Sample size distribution per district

| District | Adolescent Boys (15 - 19) | | Young men (20- 24) | | Adolescent Girls (15 - 19) | | Young Women (20 - 24) | |
|---|---|---|---|---|---|---|---|---|
| | Rural | Urban | Rural | Urban | Rural | Urban | Rural | Urban |
| Bulilima | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 |
| Mangwe | 13 | 12 | 13 | 13 | 13 | 13 | 13 | 13 |
| Matobo | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 |
| Beitbridge | 13 | 13 | 13 | 13 | 13 | 13 | 13 | 13 |
| Subtotal | **52** | **51** | **52** | **52** | **52** | **52** | **52** | **52** |
| Total | 415 | | | | | | | |

## 2.6 Ethical Considerations

To ensure ethical conduct during the study, the consultant adhered to and respected the Medical Research Council of Zimbabwe (MRCZ) requirements and Code of Conduct to actively safeguard adolescents and youths from harm and guarantee that their protection rights were fully understood. Some of the ethical considerations that were considered include.

- **Confidentiality and anonymity**: The consultant treated each response with utmost confidentiality; for example, no names were required from those who participated in the survey questionnaire, and pseudonyms were assigned to FGD participants to ensure the anonymity of responses.
- **Informed Consent**: The consultant made it noticeably clear that participation at any level was entirely up to the respondent, and there was room to withdraw from the study at any given moment. Participants were provided with information about the study prior to giving their consent to participate. Written and verbal consent were sought from each participant engaged in the study. Consent for minors was sought through community-based program coordinators who facilitated consent seeking from parents/guardians prior to field visits. Audio recording and photography consent was sought from all the participants.
- **Non-discriminatory participation**: No participant was excluded from participating on condition of their health, disability, socio-economic status, among other vulnerability criteria.

## 2.7 Data Analysis and Report Writing

Quantitative data collected using the KOBO Toolbox was downloaded from the main dashboard in Microsoft Excel format and cleaned. The cleaned data was then exported to the statistical analysis software, SPSS, for in-depth analysis. The findings were presented through frequency tables and graphs. A trend analysis of the incidence rates was computed for four years from 2018 to 2022, considering the number of new cases and the population per district.

Qualitative data collected in local languages was translated into English. The thematic analysis technique was used to code discrete units of meaning, chart relationships among these units, and describe patterns of experience in data generated from focus group discussions and key informant interviews. Rigorous triangulation was applied to compare responses across diverse participants and data sources, reducing bias and detecting inconsistencies.

**Report Writing:** The data analysis output was used to develop the findings section of the report, presented in the form of tables and graphs, as well as direct quotations. Where appropriate, pictures were provided as supporting evidence. Results from both primary and secondary data collection were used to develop the findings section.

# 3 SECTION III. FINDINGS

The findings section begins with a presentation of the quantitative survey demographics, followed by the core findings presented against i) HIV incidence for AGYW, ii) the factors that contribute to high HIV incidence and iii) the gaps in HIV programming that could be contributing to high HIV incidence among AGYW in Matabeleland South province. The findings comprise quantitative results from the survey questionnaire and opinions and perspectives from FGDs and KIIs.

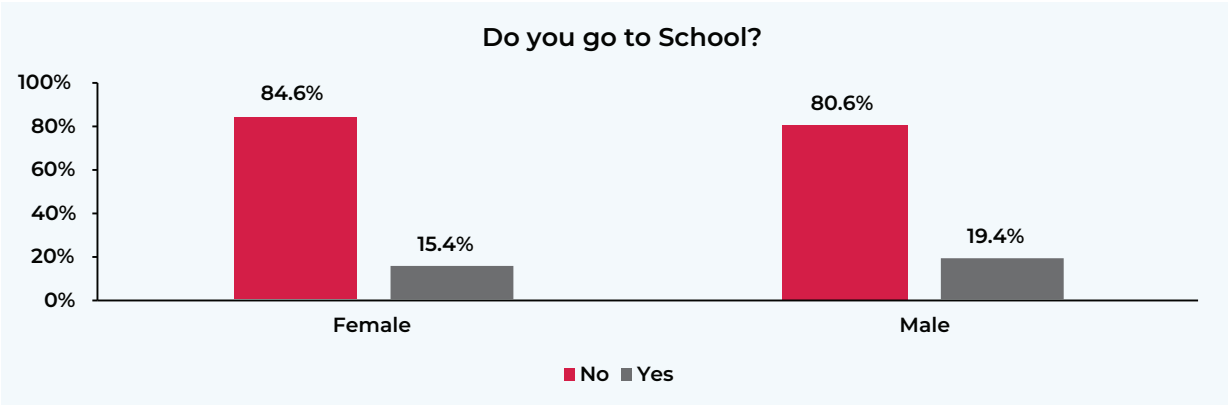
## 3.1 Demographics

This section presents the demographic characteristics of the quantitative survey participants reached during the field visits.

### Education

Of the survey participants that were reached by the study, 15.4 per cent (n=32) of female and 19.4 per cent (n=40) of male participants were enrolled in school by the time of the study, while 84.6 per cent (n=176) of female and 80.6 per cent (n= 166) of male participants were not. On the other hand, 80.8 per cent (n=84) of sampled adolescent girls were out of school, while only 19.2 per cent (n=20) were in school. Therefore, most participants (82.6 per cent; n=342) were out of school AGYW and adolescent boys and young men.

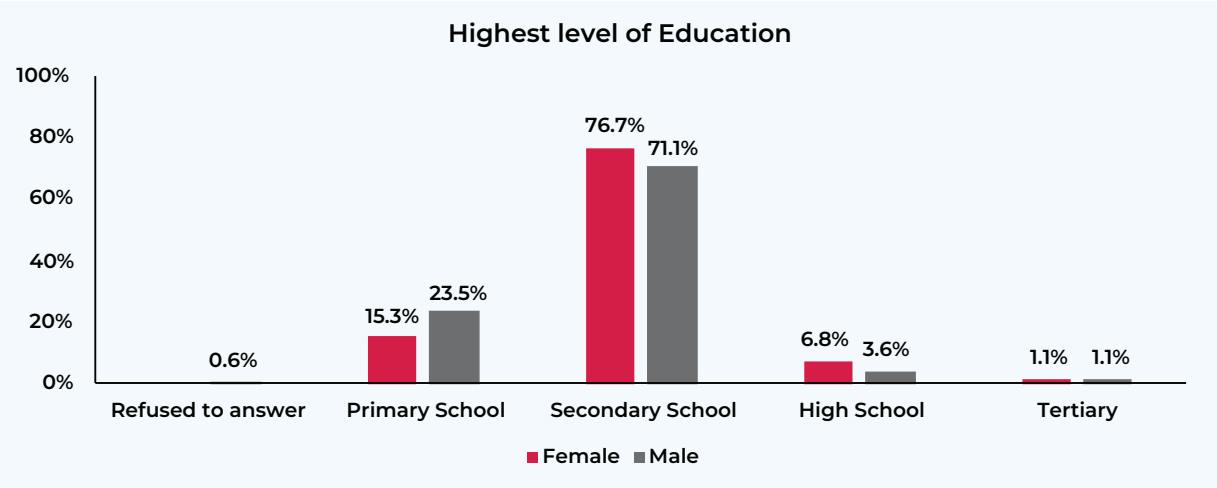

**Figure 1:** Education level.



Of the male participants who indicated that they were attending school, 1 was at the primary level, 2 were at the secondary level, 28 were at the high school level, and 10 were at the tertiary level. Of the female participants who indicated they were attending school, 22 were in high school, and 10 were at the tertiary level. Figure 2 below details the highest level of education of out of school AGYW and adolescent boys and young men.

**Highest level of education**

**Figure 2**: Highest level of education.

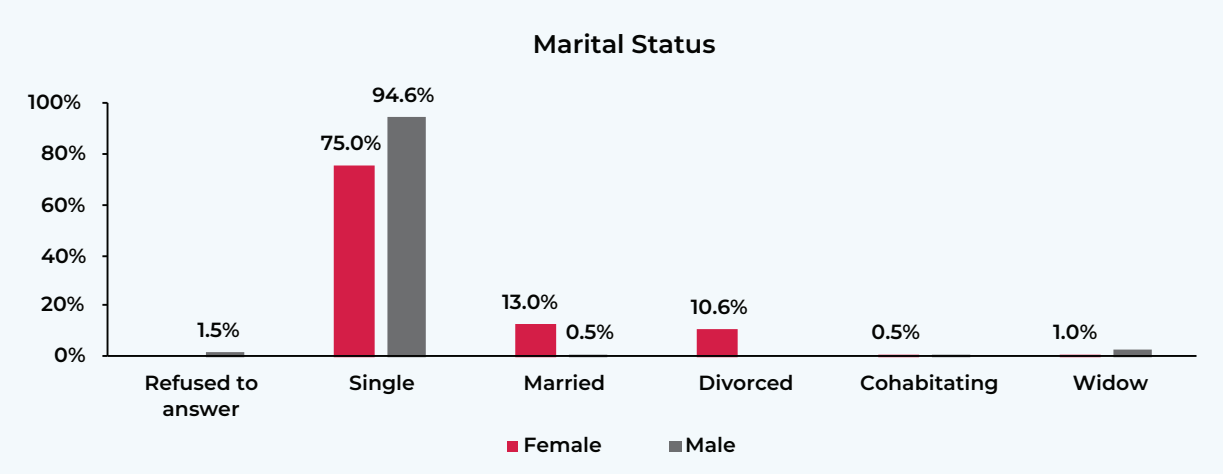



The highest level of education was enquired on, and 76.7 percent of female and 71.1 percent of male participants indicated having reached the secondary level. In comparison, 15.3 percent of female and 23.5 percent of male participants had reached the primary level. Only 6.8 percent of female and 3.6 percent of male participants indicated having reached high school, whereas 1 percent of female and 1.1 percent of male participants had reached tertiary level.

**Marital Status**

Quantitative survey participants were asked about their marital status, and 75 percen of female and 94.6 percent of male participants indicated they were single. In comparison, 13 percent of female and 0.5 percent of male participants were married. Additionally, 10.6 percent of female participants were divorced, while 0.5 percent of female and 0.5 percent of male participants were cohabitating, and 1 percent of female and 3 percent of male participants were widowed. Only 1.5 percent of male participants refused to answer about their marital status. This is illustrated in Figure 3 below.

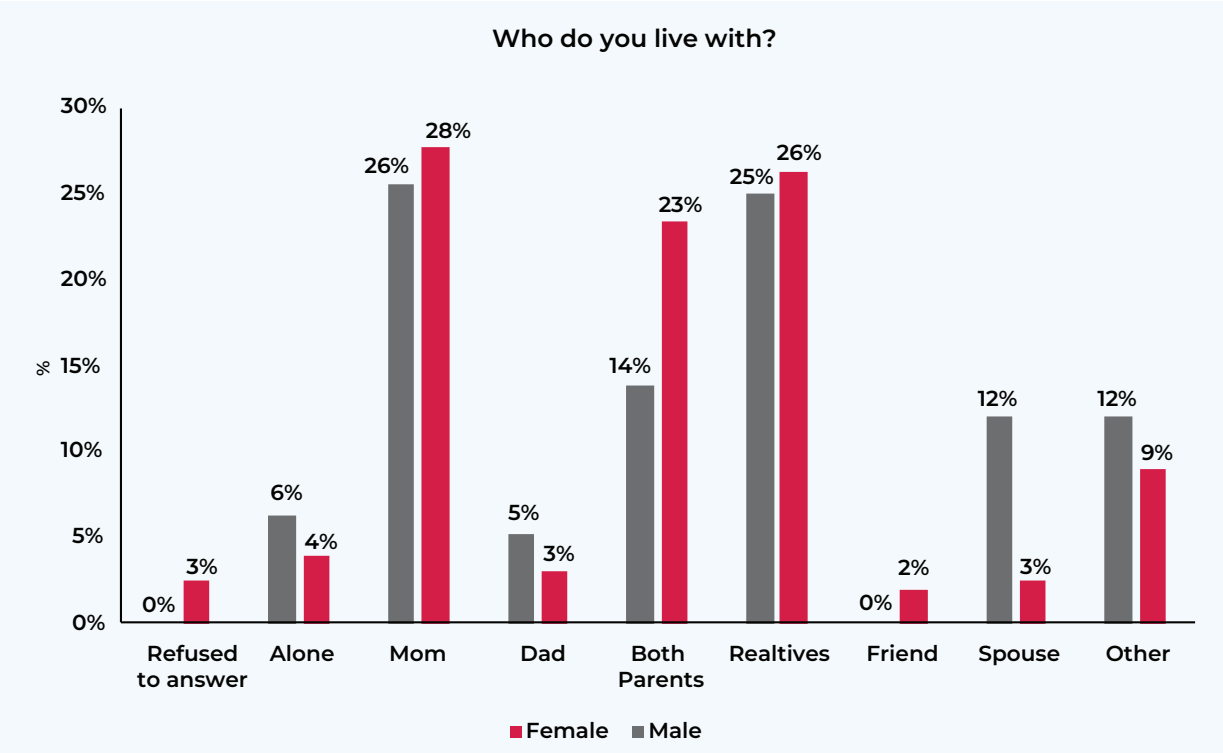
**Figure 3:** Marital status.




## Living Arrangements

Participants were asked whom they lived with, and 6.3 percent of female and 4 percent of male participants indicated that they lived alone, while 25.5 percent of female and 27.7 percent of male participants indicated that they lived with their mother. Only 5.3 percent of female and 3 percent of male participants indicated that they lived with their father. In addition, 13.9 percent of female and 23.3 percent of male participants indicated that they lived with both parents, while 25 percent of female and 26.2 percent of male participants indicated that they lived with relatives. Only 2 percent of male participants indicated that they lived with a friend, while 12 percent of female and 2.5 percent of male participants indicated that they lived with their spouse. This is illustrated in Figure 4 below.

**Figure 4:** who do you live with



### Employment

Survey participants were asked about their employment status, and 83.2 percent of female and 63.4 percent of male participants indicated that they were not employed at the time of the study. In comparison, 16.8 percent of female and 36.6 percent of male participants indicated that they were employed by the time of the study.

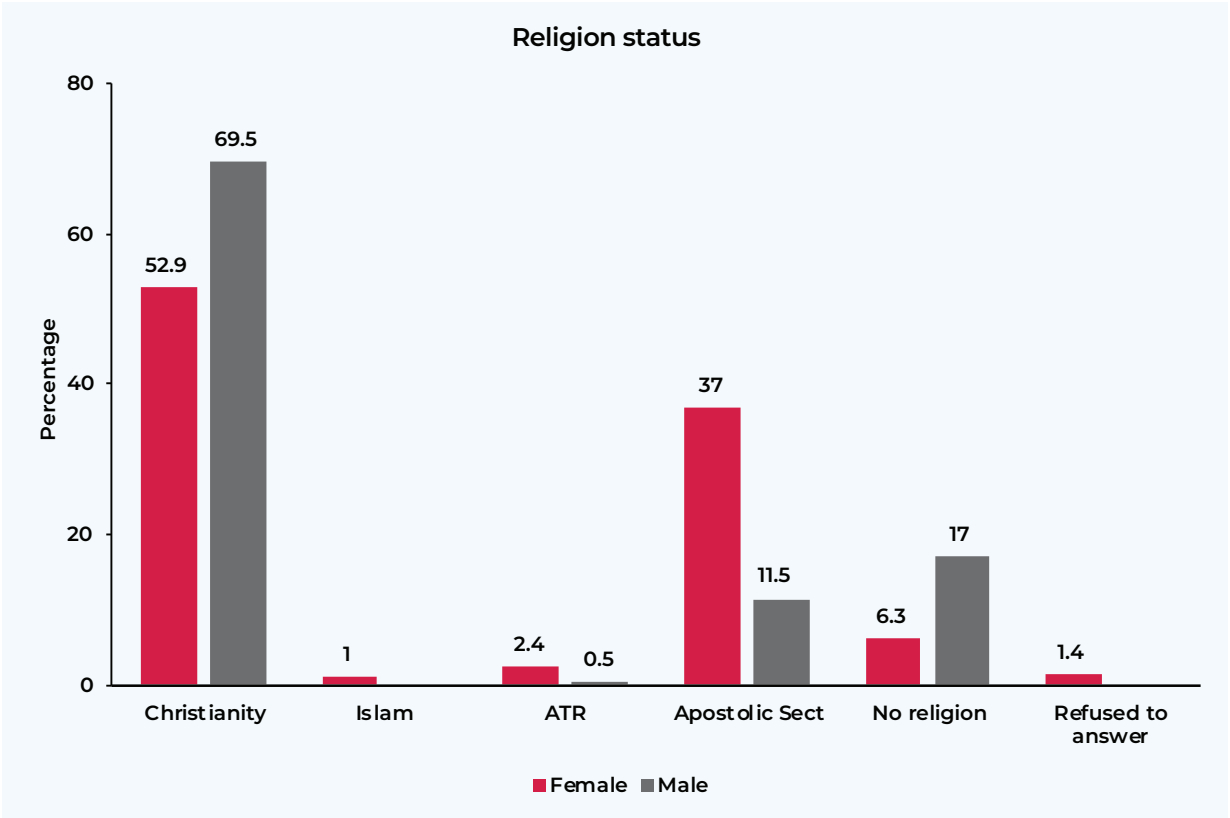
### Disability Status

Of the survey participants engaged during the study, no female participant had any form of disability, while 3.4 percent of male participants had a disability. Of the 8 male participants who indicated that they had a form of disability, 6 had a physical disability, while 2 reported speech impairment.

### Religion

Survey participants were also asked about their religion; their responses are summarized in Figure 5 below.

**Figure 5:** Religion status.



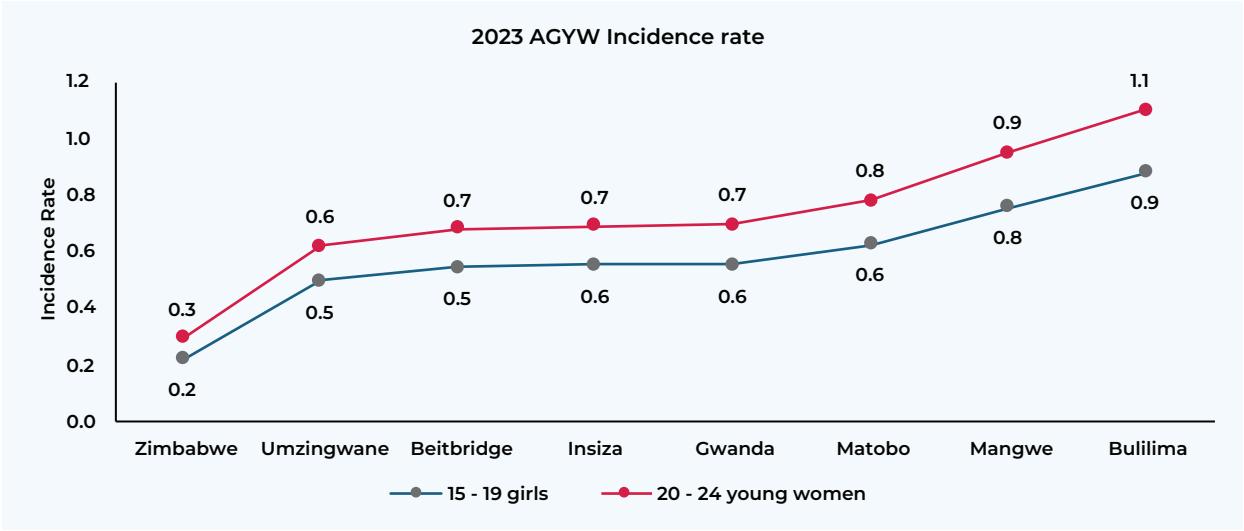

As illustrated in Figure 5 above, 52.9 percent of female and 69.5 percent of male participants indicated Christianity as their religion. In comparison, only 1 percent of female participants indicated Islam as their religion. In addition, 2.4 percent of the female and 0.5 percent of male participants indicated the African Tradition as their religion.

In comparison, 37 percent of female and 11.5 percent of male participants indicated the Apostolic Sect as their religion. A total of 6.3 percent of female and 17 percent of male participants stated that they were not affiliated to any religion.

## 3.2 HIV Incidence for AGYW in Matabeleland South

The relationship between HIV incidence and infection rate is fundamental to understanding the dynamics of the HIV epidemic. HIV incidence rate refers to the number of new HIV infections occurring within a specified population over a given period, typically measured annually. On the other hand, 'infection rate' refers to the total number of individuals living with HIV within the same population at a specific point in time.[14] These two measures are intricately linked since an increase in the incidence rate is because of more individuals acquiring HIV infections. In Zimbabwe, the HIV incidence rates for adolescent girls and young women stand at 0.2 and 0.3, respectively. However, the HIV incidence amongst AGYW in Matabeleland South surpasses the national rate, with incidence rates ranging from 0.2 – 1.1 across all districts, as presented in Figure 6 below.

**Figure 6:** AGYW Incidence

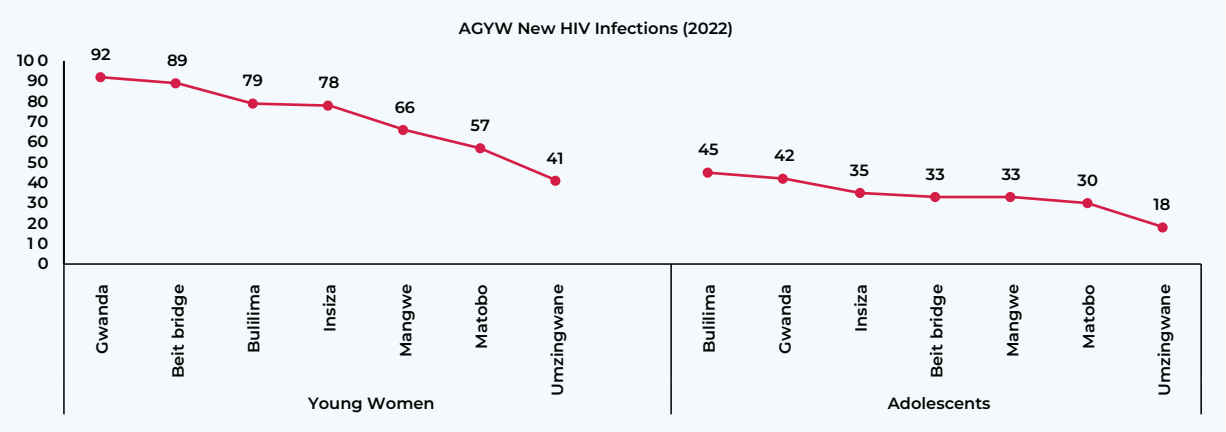



The HIV incidence for adolescent girls (15 – 19 years) was relatively lower compared to that of young women (20 – 24 years) across all districts in Matabeleland South. This finding aligns with the commonly observed trend across various regions, where the transition from adolescence to early adulthood brings about new experiences and potential exposure to risky behaviors, leading to increased vulnerability to sexually transmitted infections. Among the different districts within Matabeleland South, Mangwe and Bulilima have the highest incidence rates, between 0.8 and 1.1 amongst AGYW.

The findings presented in Figure 7 below show the estimated number of new infections among AGYW in 2022. The data was retrieved from the National AIDS Council's '*Matabeleland South Provincial and Districts HIV Estimates Report 2023*'.

14 CDC. 2024. "Terms, Definitions, and Calculations Used in CDC HIV Surveillance Publications." Accessed? https://www.cdc.gov/hiv/statistics/surveillance/terms.html

**Figure 7:** AGYW new HIV infections.

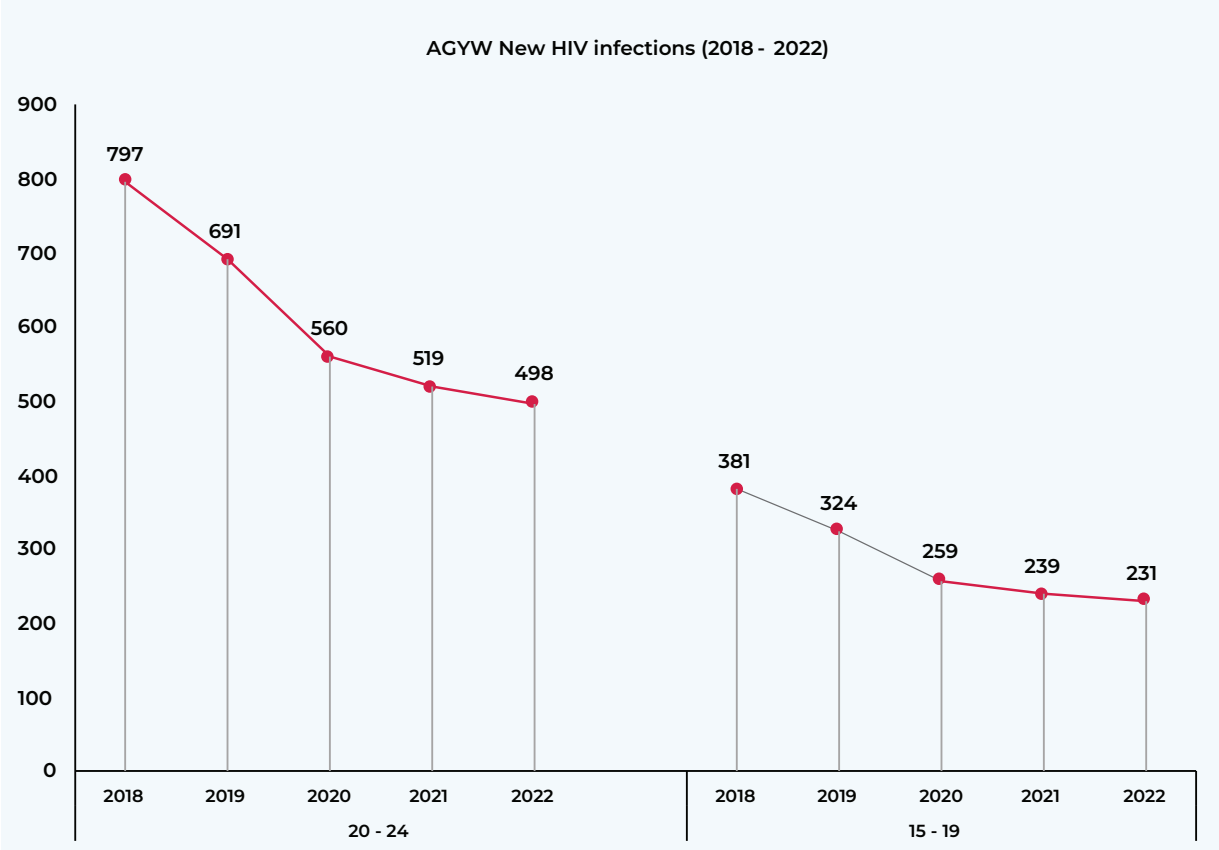



Across all districts, the number of new HIV infections among young women far surpassed that of adolescent girls. Gwanda and Beitbridge were the districts with 92 and 89 new infections among young women, respectively. New HIV infections among adolescent girls were high in Bulilima (45), Gwanda (42) and Insiza (35).

### 3.2.1 HIV New Infections Trend Analysis

Figure 8 below shows the trend in the number of new HIV infections among adolescent girls and young women from 2018 – 2022.

**Figure 8:** AGYW HIV infections.



For adolescent girls, the number of new HIV infections has been decreasing over the years. 2018 there were 381 new infections, which decreased to 324 in 2019, 259 in 2020, 239 in 2021, and 231 in 2022.[15] This indicates a declining trend in HIV infections among adolescent girls. Similarly, there has been a decrease in the number of new HIV infections among young women. In 2018 there were 797 new infections, which decreased to 691 in 2019, 560 in 2020, 519 in 2021, and 498 in 2022. This suggests a decreasing trend in HIV infections among young women as well. While both age groups have experienced a decline in new HIV infections over the years, it is important to note that young women still have a higher number of new infections compared to adolescent girls. An average decrease of 13 per cent for young women and 14 per cent per year for adolescent girls over five years is not significant enough to lower Matabeleland South's incidence rate below the other nine provinces. Important to note is that the rate of decrease in incidence has reduced in the last two years (2021-2022), and the trend is beginning to plateau, hence risking an increase in HIV incidence in the absence of appropriate interventions that curb the current trend.

Factors that are contributing to the slow decrease in HIV incidence in Matabeleland South are discussed in detail in the following sections.

## 3.3 Factors Contributing to High HIV Incidence Among AGYW in Matabeleland South

The study revealed a multiplicity of factors that contribute to high HIV incidence among AGYW in Matabeleland South. The identified factors include limited HIV information and knowledge; sex work; transactional and intergenerational sex; gender inequality; negative role models; limited economic empowerment opportunities, and concurrent multiple sexual partners, among others. These factors create intersectional vulnerability, which perpetuates inequity and increases the risk of HIV transmission. A detailed discussion of the factors is presented below.

### 3.3.1 Limited HIV information and knowledge

Spreading knowledge and awareness about HIV is one of the key strategies that is used in the prevention and control of HIV and AIDS. Inadequate information and knowledge lead to risky practices that are a major hindrance in reducing HIV incidence. Discussions with AGYW in Matabeleland South province revealed that AGYW have limited knowledge of HIV prevention methods, transmission modes and treatment, which is marred by inaccuracies, myths, and misconceptions, all of which influence their behavior. Qualitative findings reiterated the lack of knowledge of HIV transmission modes, with FGD participants being quoted saying.

> *"As a guy, I don't know what HIV is, so I can't protect myself from something that I don't know about."* **(FGD with young men, Bulilima rural)**

> *"I want to ask. If someone is HIV positive, does this mean that each body part, including the sperms, has HIV?"* **(FGD with Adolescent Girls, Mangwe Urban)**

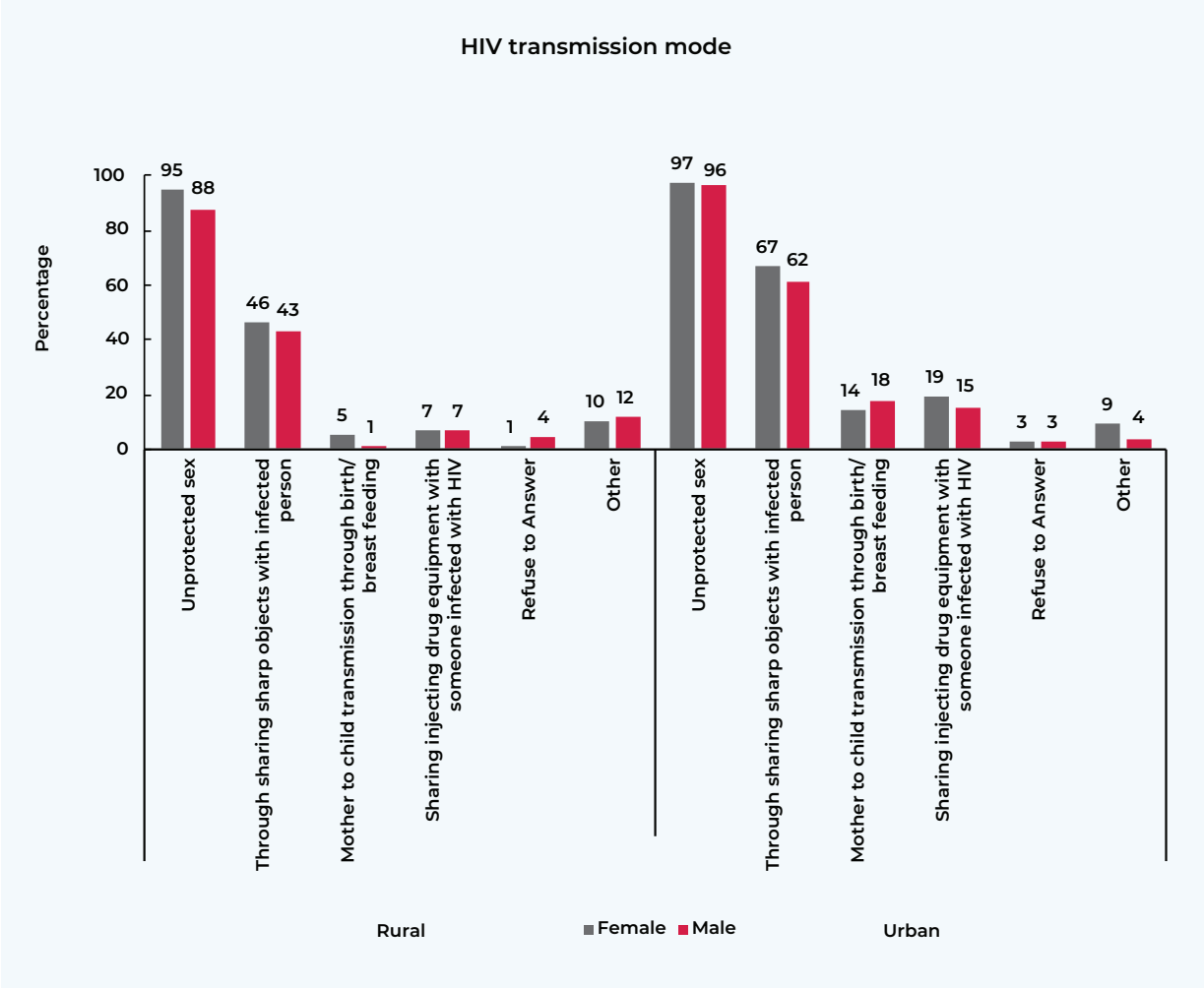
> *"And how does the sperm coincide with HIV because according to my biology education, HIV is mostly spread through blood. That is what I learnt. There is no sperm needed in that."* **(FGD with Adolescent Girls, Mangwe Urban)**

15 Matabeleland South Provincial and Districts HIV estimates report 2023.

This lack of knowledge about HIV transmission is a strong indicator that young people are not getting access to the right information. The lack of knowledge portrayed in the quotations above is evidence that some adolescent girls in Matabeleland South do not have accurate information about HIV transmission. In contrast, others do not have basic knowledge about HIV and AIDS. This is especially true for those who are not enrolled in HIV prevention programmes, as highlighted by an FGD participant who reported a limited number of AGYW participating in HIV prevention programmes in their communities.

A multiple response question was administered to survey participants to assess their knowledge on HIV transmission modes. The majority (over 50 per cent) of adolescents and young people indicated that they were aware of unprotected sex as an HIV transmission mode. However, survey participants had limited knowledge on other HIV transmission modes, and their responses are summarized in Figure 9 below.

**Figure 9**: HIV transmission mode.



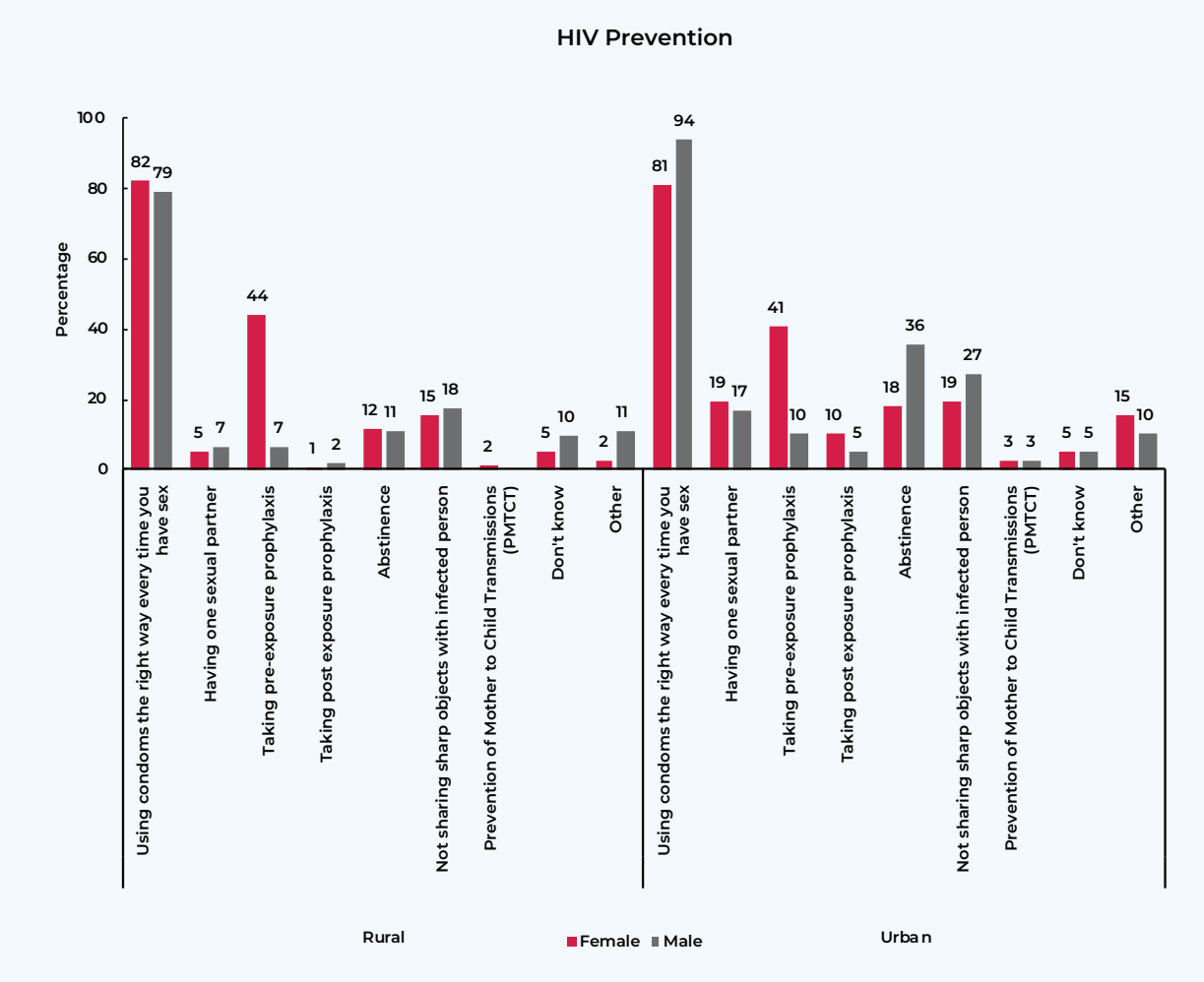

Sharing drug injection equipment with someone infected with HIV was recognized by a smaller proportion of respondents as a mode of HIV transmission. While survey participants understood the risk of having unprotected sex, only 6.9 percent (9) of female and 6.6 percent (8) of male respondents from the rural sites were aware that sharing drug injection equipment with someone infected

with HIV is a mode of HIV transmission. On the other hand, only 19.2 percent (15) of female and 15.4 percent (12) of male respondents from the urban sites indicated that they were aware.

While most survey participants knew about unprotected sex as an HIV transmission mode, sharing of drug injection equipment and mother- to-child transmission were identified by fewer respondents. Of note is that 10 percent (10) of female and 12 percent (14) of male participants from rural locations and 9 percent (8) of female and 4 percent (3) of male participants from urban locations indicated kissing and sharing bath soaps as modes of HIV transmission. In contrast, others indicated that they did not know.

Survey participants were asked how HIV can be prevented, and only 1.5 percent (2) of female participants from rural sites and 2.6 percent (2) of female participants from urban sites indicated that PMTCT was a method of HIV prevention. These findings indicate a low knowledge level of PMTCT among AGYW, as illustrated in Figure 10 below.

**Figure 10:** HIV Prevention




It is important to note that a lower percentage of respondents regarded having one sexual partner, use of PrEP and PEP or abstinence as ways of preventing HIV infections. For example, in rural areas, only 5 percent (7) of female and 7 percent (8) of male participants indicated that having one sexual partner is a way of preventing HIV infection. In contrast, in urban areas, 19 percent (15) of female

and 17 percent (13) of male participants reported the same. In addition, 44 percent (57) of female and 7 percent (8) of male participants in rural areas, and 41 percent (32) of female and 10 percent (8) of male participants in urban areas reported awareness of PrEP as an HIV prevention method. Abstinence, or refraining from sexual activity, was recognized as a prevention method by 12 percent (15) of female, 11 percent (13) of male respondents in rural areas and 18 percent (14) of female and 36 percent (28) of male participants in urban areas.

The quantitative survey findings have revealed that the AGYW's level of knowledge of HIV is higher than that of their male counterparts. This is supported by findings from a study by Mayibongwe and Mzingwane in which more female (81.1 per cent) participants had higher knowledge of HIV and reproductive behavior than male participants (71.1 per cent ).[16] However, the girls' low levels of knowledge of transmission modes such as PMTCT and prevention methods such as PrEP are of concern. Additionally, the ZIMPHIA 2020 report found that only 31.6 per cent of study participants in Matabeleland South answered the five HIV knowledge questions correctly, which was lower than all other provinces except Matabeleland North.

These low levels of knowledge are further compounded by myths and misconceptions about HIV. These widely held but false beliefs, as well as uninformed views and opinions, fuel HIV transmissions among AGYW in Matabeleland South. Holding such misunderstandings can have dire consequences on the decisions that AGYW make in their lives, leading to an increase in HIV incidence in this age group. Some of the myths and misconceptions stated by adolescents and youths are listed in **text box 1.1,** where most of the myths and misconceptions came from adolescent boys and young men.

16 Mayibongwe L. Mzingwane et al. 2020. "A Study on HIV Knowledge, Risky Behaviors and Public Health Care Services Attendance Among Adolescents from the Grassroot Soccer Zimbabwe Programme." BMC Health Services Research, 20(1), Pp. 1-8.

**BOX 1.1**

**Myths and misconceptions by adolescents and youth**

"HIV can be transmitted by sharing the same bath soap with an HIV positive person." (FGD with adolescent boys, Beitbridge)

"There is a possibility to not get HIV because men do not transmit HIV, but girls do." FGD with Adolescent Girls, Mangwe Urban)

"HIV is transmitted through blood and not through the man's sperms." (FGD with Adolescent Girls, Mangwe Urban)

"People don't go for testing because they use traditional herbs ...the Mbengauweni thula-midzi (Kalanga)...which cleans the body system from HIV." (Bulilima rural FGD- Adolescents Boys)

"We use what we call VAT scanning (Visual AIDS Testing) to see if a girl has HIV or not." (FGD with young men Mangwe)

"When we have sex with beautiful girls, we just do it without protection... they will be too beautiful to have HIV" (FGD with young men Plumtree rural)

"HIV is transmitted by girls." (FGD with adolescent boys, Matobo)

"Some sugar daddies believe if they sleep with someone who is HIV negative or a virgin they will be cured of HIV." (FGD with adolescent boys, Beitbridge)

"If you put a rusty nail in water and drink the water, when you sleep with a girl, the HIV is transferred to the girl then you become HIV negative, but you should never sleep with the girl again." (FGD with young men, Bulilima)

"The elderly will be really loving you and you will be the only one. Usually, they do not double cross you." (FGD with young women Maphisa urban)

Considering that adolescents and young people aged 15-24 were born after the peak of the HIV epidemic, they may not have received the same level of HIV education and facilitation as previous generations who experienced the height of the epidemic. Hence, adolescents and young people, especially boys, have myths and misconceptions that lead them into risky sexual behaviors, which in turn increase HIV infections among AGYW.

**Low Risk Perception**

Matabeleland South faces significant challenges in combating the spread of HIV due to the low-risk perception among its population. Despite efforts to raise awareness about HIV prevention and transmission by NGOs and CSOs, adolescents and young people engage in risky sexual behaviors. Findings from the study revealed that one contributing factor to the minimal risk perception is a misconception surrounding circumcision among adolescent boys and young men. FGD participants had this to say:

> *"If I am circumcised, I will never catch HIV... I can have unprotected sex with different women."* **(FGD with adolescent boys, Beitbridge, urban)**

While circumcision has been shown to reduce the risk of HIV transmission, it does not provide complete protection.[17] According to the Centres for Diseases Control and Prevention (CDC), male circumcision can reduce a male's chances of acquiring HIV by 50-60 per cent during heterosexual contact with female partners with HIV. However, adolescent boys and young men in Matabeleland South falsely believe that being circumcised makes them immune to HIV, leading to disregarding safe sex practices and increasing AGYW vulnerability to infection. By solely relying on circumcision as a means of protection, these adolescent boys underestimate the potential risks associated with unprotected sexual encounters.

Furthermore, FGDs revealed that some adolescents and young people, particularly young boys, believe that they are invulnerable to HIV due to their young age. This perception stems from a lack of understanding about the risks associated with unprotected sex and a belief that HIV only affects older people. As a result, these adolescents and young people engage in risky sexual behaviors without considering the implications. The low-risk perception found among adolescents and young people also manifests itself in the multiple concurrent sexual relationships that study participants attested to. Having multiple sexual relationships has long been recognized as a significant contributor to high HIV incidence, as it increases the risk of exposure to the virus and facilitates its transmission within communities. The existence of multiple sexual partners in Matabeleland South was highlighted by adolescents and young people who said:

> *"Even the girls have many boyfriends. One girl can have six boyfriends and one blesser, and when the blesser infects the girl with HIV, she also spreads it to her other boyfriends. And obviously the 6 boyfriends will be having other girlfriends, and they also spread to the next..."* **(FGD adolescent girls Mangwe urban)**

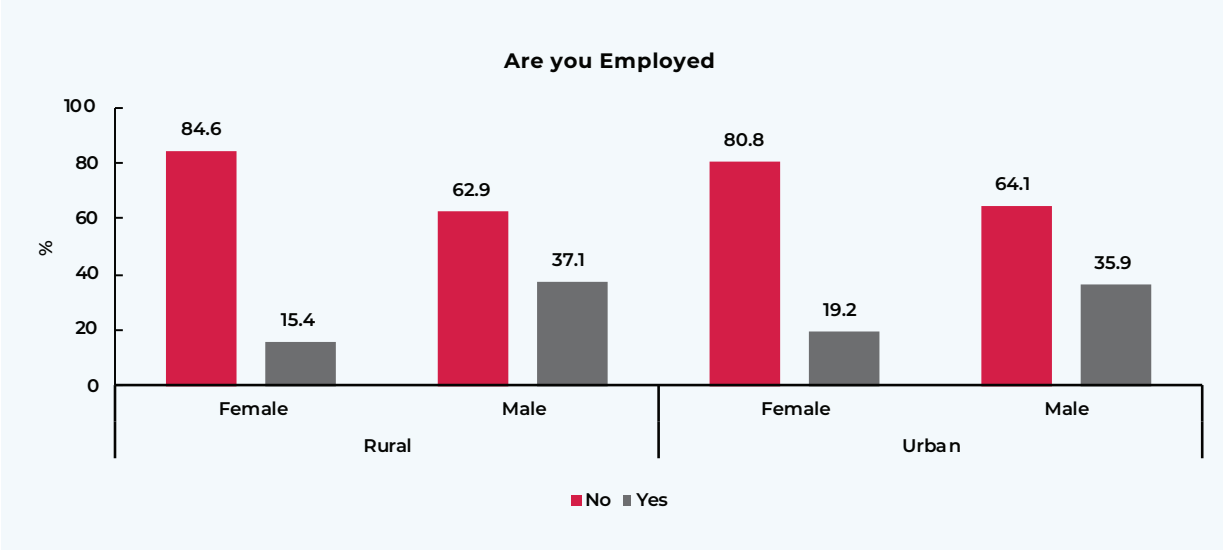
This reflects serious lack of awareness and understanding of HIV transmission, which is compounded by low-risk perception of contracting HIV.

### 3.3.2 Poverty and Limited Economic Empowerment

Findings from the study revealed that poverty and lack of economic empowerment among AGYW play a critical role in increasing HIV incidence in the province. The quantitative survey enquired about the employment status of the sampled participants, and their responses are summarized in Figure 11 below.

17 CDC. nd. "Male Circumcision for HIV Prevention Fact Sheet." Accessed? https://www.cdc.gov/nchhstp/newsroom/fact-sheets/hiv/male-circumcision-HIV-prevention-factsheet.html#:~:text=Heterosexually%20active%20adolescent%20and%20adult,other%20STIs%20during%20heterosexual%20contact

**Figure 11:** Employment status.




Most sampled survey respondents indicated that they were not employed, with 84.6 percent of female and 62.9 percent of male participants in rural areas, and 80.8 percent of female and 64.1 percent of male participants in urban areas, reporting that they were not employed. This indicates that young people, despite their different geographical locations, face similar economic challenges that fuel HIV infections in Matabeleland South. The nexus between unemployment and poverty has resulted in AGYW engaging in unprotected sex without knowing their intimate partner's status to get financial benefits to sustain themselves.

Complimentary to the quantitative findings were focus group discussions with young women who revealed that poverty and unemployment are major drivers of HIV in Matabeleland South. These factors drive AGYW into sex work as they seek economic survival. Women's economic dependence on men increases their vulnerability to HIV by constraining their ability to negotiate for safe sex. Furthermore, young mothers aged between 15 and 24 years end up engaging in transactional sex and intergenerational sex to sustain their families. Study participants had this to say:

> *"They fail to feed themselves, and then they end up selling their bodies for a dollar for two rounds, which is very popular in Beitbridge...it is an issue of not getting enough food on the table."* **(KII with stakeholder, Beitbridge)**

> *"Here in Maphisa, most girls do not have employment. So, sex work is the only easy way they get money, sex work is their employment, and, in most cases, they don't protect themselves."* **(FGD with young women Matobo Urban)**

Moreover, findings identified poverty in the family as one of the main factors limiting school attendance due to lack of money to pay school fees, which leads to AGYW dropping out of school. This economic vulnerability increases early and child marriage, which fuels HIV infections among AGYW in Matabeleland South. Some of the AGYW intentionally fall pregnant or get into early marriages as they will be desperate for survival and in need of a man who can take care of them. The study also found that some parents face economic burdens, and by marrying off their daughters, they believe that they will be able to alleviate financial strain. A focus group discussion with adolescent girls pointed this out saying:

> *"Early marriages are there. Sometimes, a child is made to get married due to the poverty situation which is at home. The child can be made to get married to a rich man because they know that the family will be elevated with the help of the in-laws."* **(FGD with Adolescent Girls, Mangwe Rural)**

The lack of viable economic opportunities increases idleness among AGYW, which subsequently leads to risky sexual activities, becoming pregnant early and/or contracting HIV.

### 3.3.3 Negative Role Models

Role models have the passion, ability, and platform to inspire young people to emulate their success and inspire faith and confidence in them to achieve their goals. Role models often influence young people's actions in the form of imitation and motivate them more than their immediate families. However, it is prudent to note that not all role models provide positive inspiration, but some influence young people negatively. Study findings highlight negative role models for AGYW as elaborated by FGD participants who said:

> *"Why should I waste my time at school yet there are no jobs, while sex work pays? Sex workers in my community have money here in Beitbridge. They do not struggle for anything."* **(FGD with young women, Beitbridge Urban)**

> *"Sex workers are always smart with their nice hair and nails, and new phones... We also want to be like them."* **(FGD with adolescent girls, Mangwe Urban)**

AGYWs desire to have material things has fuelled them to view sex workers as their role models and to place little value on education. The study found that the lack of gainful employment opportunities and economic activities has allowed sex work to be viewed as a viable avenue for income generation despite the considerable risk of contracting HIV and other sexually transmitted illnesses. On the other hand, adolescent boys and young men were also found to have the *malaitsha*[18] drivers as their role models because they admire the cars they drive and the lifestyles they portray when

18 People who are hired to ferry goods across borders.

travelling across the border. Additionally, the fact that they drive good cars and have money to spend despite being school dropouts makes adolescent boys place little to no value on their education. A stakeholder spoke on this saying:

> *"They have these malaitsha who never went to school, but they drive magnificent cars around. So, they say, you see, here is a teacher who is highly educated, but he is suffering. He does not even have a car. So, they would say, when I grow up, I would like to be a malaitsha and buy a four by four, GD6, and have many girlfriends."* **(KII with stakeholder, Bulilima)**

In addition to this, AGYW now want to be associated with this role model, the *malaitsha*, particularly because they have cars and money from which they can benefit. This further highlights the effects that negative role models have had on adolescents and young people. It is through this association with the *malaitsha* role models that adolescent girls and young women risk contracting HIV.

Cross-border men, popularly known as *'injiva,'* were reported to have lots of money and cars that they use to lure AGYW into sexual relationships with them, especially during festive seasons. Findings also showed that most cross-border men are illegal immigrants who have limited access to HIV prevention services in foreign countries. When they return home for the festive holidays, they contribute to an increase in teenage pregnancies and HIV infections among AGYW due to the '*injivas'* financial power to demand unprotected sex.

The negative role models, including some secular musicians, influence AGYW into attending parties where they engage in unsafe sex. These role models are not only from within their locality but also from the international arena. FGD participants were quoted saying:

> *"You will be imagining yourself as Rick Ross while you're high. The lifestyle of these musicians is also contributing to us taking drugs. If I see Emtee smoking, I will be like, let me try what Emtee is doing because it's cool."* **(FGD with Young Men, Beitbridge Urban)**

> *"...so, people will be telling themselves, I want to be like Burna boy, a weed smoker. Social media is contributing too."* **(FGD with Young Men, Beitbridge Urban)**

Considering that boys are inspired by the musicians who engage in drug and substance abuse, this subsequently results in boys sexually abusing AGYW, for example, through spiking the girls' drinks and gang raping them. Through social media platforms and exposure to the lives of famous individuals, the boys pick up on inappropriate traits. On the other hand, the girls emulate sex workers for money and material gain to become more like or be associated with their role models. In so doing, both AGYW and their male counterparts become careless and end up engaging in unprotected sex.

### 3.3.4 Sex Work, Intergenerational and Transactional Sex

Sex work[19] is viewed as a commercial business or paid employment in the sex industry whereby one gets paid in exchange for sex. At the same time, intergenerational sexual relationships[20] are sexual relationships between people with an age difference of ten or more years. Transactional sex is defined as "non-marital, non-commercial sexual relationships motivated by the implicit assumption that sex will be exchanged for material benefit or status".

The role of sex work in increasing the HIV infection rate among AGYW in Matabeleland South is a critical issue that warrants attention and targeted interventions by all stakeholders. Findings from the study revealed that the prevalence of sex work among AGYW in Matabeleland South is a concerning reality driven by various factors, including economic hardships, peer pressure, limited employment opportunities, and poverty, among others. These circumstances push AGYW into engaging in sex work as a means of survival and income generation. A FGD participant was quoted saying:

> *"As a sex worker, I have kids that I need to take care of...so if a client comes and tells me that I will give this much to have unprotected sex with you, I will just consent because I need the money."* **(FGD with Adolescent Girls, Mangwe Urban)**

Given the extent of the challenges that AGYW are facing, sex work creates a context where the need for immediate financial resources often outweighs considerations of personal well-being and the risk of contracting HIV.

Further exacerbating the HIV infection rate, AGYW sex workers in Matabeleland South have male sex clients who offer more financial incentives for unprotected sex, with some men offering as much as US$200 for unprotected sex as opposed to US$20 USD or less for protected sex. Unfortunately, this leads to situations where sex workers prioritize financial gain over their well-being, increasing the risk of HIV infections.

AGYW sex workers, particularly in Beitbridge and Mangwe, were found to be highly vulnerable to HIV and other sexually transmitted infections (STIs) due to multiple and intersecting vulnerabilities that include multiple sex partners, unsafe working conditions due to violence and abuse, drug and substance abuse, and barriers to the negotiation of consistent condom use, among others. During an FGD with sex workers, adolescent sex workers were reported to be flooding the sex work industry and overtaking the adult sex workers, even though they do not have the resources or ability to pursue legal action against clients who sexually assault them. Despite their vulnerability and risk, AGYW aspire to be sex workers whom they view as their role models. One adolescent girl was quoted saying:

> *"Let me tell you, when I become a sex worker, I will be strict with payments. I will tell you that before we have sex, you have to pay. You cannot have sex with me."* (**FGD adolescent girls, Mangwe Urban)**

19 Oxford Reference. Accessed? https://www.oxfordreference.com/display/10.1093/oi/authority.20220803100458943

20 Mamba F, Shongwe MC. 2022. "Prevalence and Factors Associated With Intergenerational Sexual Partnerships Among Undergraduate Health Science Students in Eswatini." Africa Health Sciences22(2), Pp. 436 443

On the other hand, intergenerational sexual relationships occur mostly between AGYW and older men, popularly known as "sugar daddies" or "blessers". Intergenerational sexual relationships in Matabeleland South are putting adolescents and young women at an increased risk of sexually transmitted infections (STIs), including HIV. Findings from the study found peer pressure among AGYW to be a major reason for getting into sexual relationships with older men. FGD participants shared their thoughts on this, saying:

> *"...It's all because of peer pressure, especially girls... those rich guys lure the girls, and the girls are pressured into it because of hunger, poverty and their family background. So, when that old man just says hi, they already give in and don't even care of the old man's HIV status. They will be thinking of all they can get from the rich man..."* **(FGD with young women Beitbridge urban)**

> *"So, you will think that the young man cannot give me much, but the elderly person has more money and can buy you a phone, buy you clothes and give you money, which cannot be done by a young person."* **(FGD with young women, Matobo urban)**

While the blessers offer benefits as outlined in the quotes above, these benefits come with a variety of risks, including sexually transmitted infections, HIV, and teenage pregnancy. The pressure that AGYW feel to want to have more than they have, be it monetary or materialistic, such as phones, clothes, and hair, increases their risk of contracting HIV, particularly in relationships where they have limited power to negotiate for safe sex. The lack of power to negotiate for safe sex practices, combined with coercion, manipulation, abuse, and the desire to maintain financial support, leads to unprotected sexual encounters and HIV transmission among AGYW. A FGD participant said:

> *"When you tell someone to use the condom, and they are elderly, they just tell you that you cannot tell me to use a condom when I am paying my money."* **(FGD with young women, Matobo urban)**

Considering the age gap that characterises intergenerational relationships, the extent to which AGYW can negotiate for safe sex and/or demand HIV testing prior to any sexual activity is limited. Gender-based violence was also found to characterise intergenerational and transactional relationships, with AGYW pointing out that requesting to have protected sex may result in older men beating them. However, due to the AGYW needing the financial and material benefit from the older men, AGYW do not report such cases of abuse. Qualitative discussions in Matobo and Beitbridge revealed that AGYW fight among themselves over blessers or sex work clients, as stated by one FGD participant who said:

> *"We have seen it, when some girls expose each other, and end up fighting and stabbing each other to get sex customers."* **(FGD with young men Matobo rural)**

Additionally, the risk of AGYW contracting HIV through intergenerational relationships further increases because of the multiple sexual partners that older people may have, considering that some may be married men and may have had other sexual relationships. Spousal separation also emerged as a factor that is driving older men into intergenerational and transactional sexual relationships with AGYW. This was evident in Beitbridge and Mangwe, where road construction, immigration workers, and illegal smugglers were cited as being the most common perpetrators of transactional and intergenerational sex. Businessmen were also reported to engage in transactional and intergenerational sex across all the visited districts, ultimately increasing HIV transmission.

While intergenerational and transactional sexual relationships have been commonly found between AGYW and older men, they are also becoming increasingly common between older women (sugar mummies) and adolescent boys and young men (Ben 10s). A FGD participant:

> *"Even boys want sugar mummies. It's all about money. Boys want to drip and bling; they want to live that nice lifestyle... sometimes the situation at home will force you to get a sugar mummy who sponsors your bills and food. The parents will be trying to provide, but it won't be enough."* ***(FGD with young men, Beitbridge urban)***

> *"The sugar mummy will give me money for data. You will be driving a car for free; she buys you fuel, chains, and clothes. There are plenty of them (sugar mummies) in Beitbridge, and they want unprotected sex, and you cannot say no because you want to please her so that they provide you with money and everything that you want."* **(FGD with young men Beitbridge urban)**

The opinions presented above again reflect monetary and materialistic benefits as a pivotal factor driving young people into intergenerational relationships, including adolescent boys and young men. Although adolescents and youth engage in intergenerational sexual relationships, they also maintain sexual relationships with their peers. This subsequently increases HIV transmission rates amongst AGYW.

**BOX 1.2**

**Intergenerational and Transactional sex by adolescents and youth**

'With sugar mummies if u give them 4 rounds of sex, they will pay you R9000 so you go for shopping, if you're being paid R1000 in your current job and you get R9000 from a sugar mummy u will end up leaving your job and working with sugar mummy's full time." (FGD with young men Beitbridge urban)

HIV risk is particularly significant if one or more individuals within a network of sexual partners that include sex work clients, sugar daddies/blessers, sugar mummies, Ben 10s and the AGYW are unaware of their HIV status and engage in unprotected sex. The ensuing dynamic leads to a heightened risk of sexually transmitted infections, including HIV.

### 3.3.5 Drug and Substance Abuse

Drugs and alcohol have usually been associated with an increased likelihood of engaging in behaviors that elevate the risk of HIV acquisition, transmission, and incidence, and this was confirmed by findings from the study. In Zimbabwe, where HIV is primarily sexually transmitted and prevalence is high, the use of alcohol and other psychoactive substances may assume particular importance in the transmission dynamics of HIV and other sexually transmitted illnesses.

Findings from the study noted extensive drug and substance abuse in Matabeleland South province, particularly in the border towns of Beitbridge and Plumtree. This was echoed by study participants who were quoted saying:

> *"Drugs are there in Beitbridge. Codeine and mbanje (Marijuana) are plenty and at affordable prices... so in Beitbridge, you will always find them in any amount. Rfive can buy a mbanje stick/danda', they sell it already rolled, ready to light."* **(FGD with young men Beitbridge urban)**

> *"If you go in these houses here, you find that drugs are being sold everywhere by both grownups and young people, including people who sell chips at the school gates, they will also be selling drugs. And the children know who sells drugs."* **(KII with stakeholder, Matobo)**

Focus group discussions in Matabeleland South revealed that drug and alcohol abuse was common among adolescents and young people and that it was closely related to risky sexual behaviours. For example, in Umzingwane, girls were reported to be taking "*intshenku" (a cheap and highly intoxicating substance).* In Beitbridge, AGYW were reported to be taking *guka/dombo* or crystal meth, while in Matobo, marijuana is used to drug AGYW during parties. Drug and alcohol abuse by AGYW was reported to be common during parties that are popular in both rural and urban areas. These parties appear to provide the only entertainment for young people. AGYW were reported to

be "*flooding*" the night clubs that are open throughout the night and have no entry age restriction, for example, at Maphisa. The amount of unprotected sex that takes place during these parties and at night clubs when the AGYW are under the influence of drugs and/or alcohol, exposing AGYW to HIV infections. Not only do girls engage in casual unprotected sex, but they are also abused and taken advantage of. Discussions with young men revealed the amount of abuse that AGYW are subjected to when they are under the influence of drugs and/or alcohol, as illustrated by a FGD participant who said:

> *"...and when girls get drunk, they won't be able to say no to sex, and so there are scenarios whereby if a girl becomes drunk, we can even take turns to have sex with her because she won't be aware of what is happening... what happens during parties is that if there are seven of us and she is just alone, we all have sex with her...some may use protection and others may not."* **(FGD with adolescent boys, Beitbridge Urban)**

Boys also reported that sometimes girls become unconscious after taking drugs, and this provides an opportunity for any man to have sex with them. This was reiterated in Mangwe, where a FGD participant was quoted saying:

> *"When girls drink alcohol and get drunk at the parties, they are usually taken away by different men whom they don't even know, who sleep with them without wearing condoms, and this is how HIV spreads."* **(FGD with adolescent boys, Mangwe urban)**

The AGYW acknowledged that they take alcohol, hot stuff, and marijuana during parties and that when they get drunk, they become impetuous and unable to make conscious decisions. A FGD participant said:

> *"I think we get too excited at bars, then we are just picked up from the bar...we get drunk and end up having sex with many people."* **(FGD with adolescent girls Matobo rural)**

What increases AGYW's risk of contracting HIV is that men of all ages, from adolescent boys to adult men, are even more engaged in drug and substance abuse, and they also flood the night clubs and parties. These men were reported to be drugging the AGYW with different forms of drugs to completely disempower them for their satisfaction. Moreover, some young men reported that they find themselves wanting to have sex more when they are drunk than when they are not, and that sex is more pleasurable when they are under the influence of drugs or alcohol. Drugs and alcohol are readily available, accessible, and affordable and that men engage in unprotected sex. One FGD participant was quoted saying:

> *"If one has taken guka and they find a girl at a bar, they will be having sexual marathons without using condoms as they will be too drunk to even think of protection."* **(FGD with young men, Mangwe urban)**

Further exacerbating the abuse of AGYW are sporting events where risky behaviors and vulnerabilities are intensified. Findings from the study indicated that in most places visited, there are limited recreational facilities, leading to a concentration of activities in specific locations and events. This results in increased risky behaviors, including unsafe sex practices and substance abuse, which contribute to the spread of HIV. One key informant had this to say:

> *"We now have an issue of recreational facilities, especially here in Beitbridge, where sports tournaments have become platforms for engaging in bad things that will make them contract HIV..."* **(KII with Stakeholder, Beitbridge)**

Uncontrolled recreational events allow for high-risk sexual behaviors and poor health outcomes, particularly among AGYW, who are more vulnerable. Moreover, the dangers of drug and substance abuse and its role in increasing HIV incidence among AGYW highlights the importance of creating safe recreational environments and fostering open conversations about sexual health.

### 3.3.6 Non-use of condoms

The non-use and inconsistent use of condoms remains a significant challenge in HIV prevention efforts worldwide. Condoms are a vital tool for reducing the transmission of HIV and other sexually transmitted infections (STIs).[21] The use of condoms as an HIV prevention method was well known among the sampled AGYW and their male counterparts, as illustrated by findings from the quantitative survey. In rural areas, 82.3 per cent (n=107) of female and 78.9 per cent (n=101) of male participants reported awareness of using condoms as an HIV prevention method. In contrast, in urban areas, 80.8 per cent (n=63) of female and 93.6 per cent (n=73) of male participants reported the same. However, despite this knowledge, the study found non-use and inconsistent use of condoms to be common among AGYW in Matabeleland South. They reported that they had lost confidence in the condom partly because they often got cheated by men and boys, as was confirmed by a male FGD participant who said:

> *"Sometimes us as gents we tear condoms just in the name of fixing a girl who over prides herself, so from that attitude, you end up tearing a condom during sex without her knowledge trying to impregnate her."* **(FGD with young men Bulilima)**

Data gathered from the discussions with AGYW, and their male counterparts showed that men generally prefer unprotected sex because they believe that condoms reduce sexual pleasure. This perception discourages the consistent use of condoms as an HIV preventive measure. It was also

21 Ibid.

found that societal beliefs contribute to the inconsistent and non-use of condoms, as AGYW are perceived to be of loose morals if they move around with condoms. Discussions with young men indicated that if a girl offers a condom to her partner for sex, she is suspected to be HIV positive or that she lacks trust in her partner's HIV status. This subsequently discourages her from negotiating for safe sex. One young man had this to say:

> *"When girls are the ones who bring the condoms, it causes much conflict in the relationship because it makes me look like I have HIV, and I won't understand it when you just bring condoms..."* **(FGD with young men, Mangwe Rural)**

This fear of judgment and stigma associated with condom use hinders its adoption as condoms are stigmatized as markers of infidelity, suspicion, and mistrust, which in turn negatively impact condom use.

Furthermore, the non-availability and non-accessibility of condoms were reported by some participants as a factor that contributes to HIV transmission in the province. Participants indicated that, at times, they needed to travel as far as 40km to get free condoms, and in some cases, when they got to the clinics, the condoms would not be available. In addition, participants mentioned the influence of some HIV prevention methods, such as pre-exposure prophylaxis (PrEP), which was reported to diminish the perception of the importance of condoms, which further reduces their uptake.

### 3.3.7 Non-disclosure of HIV status

HIV transmission can be vertical or horizontal. While vertical transmission refers to HIV being transmitted from mothers to their offspring, horizontal transmission occurs when the virus is transmitted among individuals, for example, through unprotected sex. Disclosure of one's HIV status to an intimate partner or significant other applies in both instances. Another layer of disclosure is when parents need to disclose their HIV status to their children, and by extension, parents or guardians disclosing HIV status to adolescents living with perinatally acquired HIV. HIV status disclosure is vital for HIV prevention and treatment, both of which have a direct impact on HIV incidence.

***HIV status disclosure by parents/caregivers***

Interviews with community councilors and Headmen in Matobo district showed that parents or guardians do not disclose the perinatally acquired HIV status of their children, keeping them ignorant of their status even when the children become sexually active. This presents a considerable risk of HIV infection, leading to high HIV incidence among AGYW in the province. Parents were reported to believe that if their children were to know the truth about their HIV status, they would regard their parents as the source of infection, which could cause parent-child confrontation. Most parents were reported to find it challenging to prepare for such a conflict mentally and emotionally with their children. One community leader was quoted saying:

> *"The presence of HIV in the family is kept a top secret, making sure that people within their neighborhood and some members of the family are not informed and do not have access to hospital documents and ART bottles that would indicate that a member of the family has HIV."* **(Discussion with Stakeholders, Matobo)**

Parents and guardians were reported to fear robbing their children of the happiness of living without the knowledge of being HIV positive, and they also feared making their status known to more people through third party disclosure. In addition, discussions with AGYW showed that parents preferred their children to live happily ignorant of their HIV status since related stress would negatively impact their education and their lives. An interview with an adolescent girl showed that she was not aware of her status, but she was consistently collecting ARV pills from the hospital with her grandmother. She said:

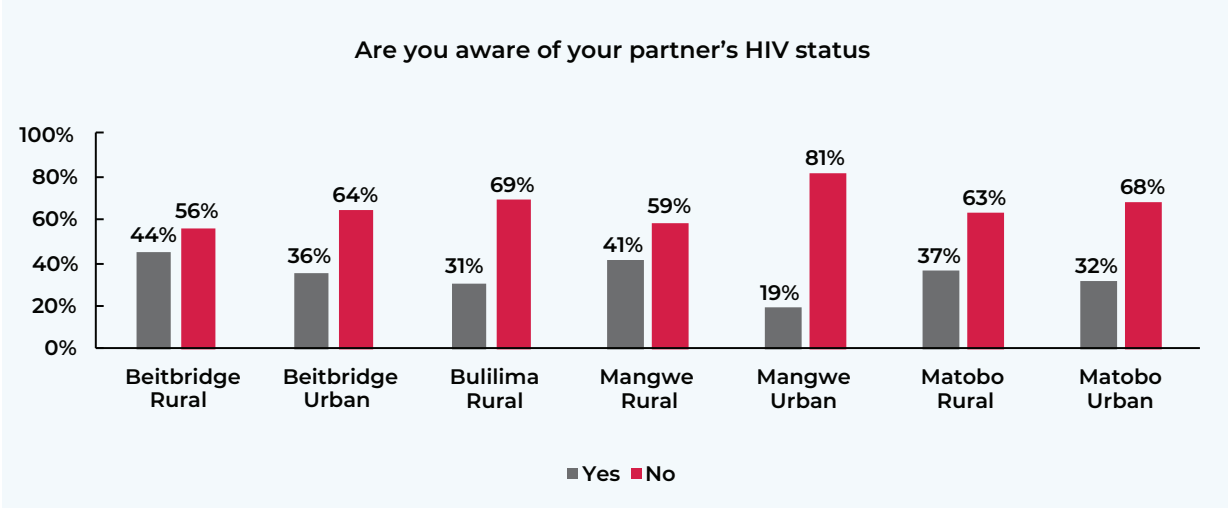
> *"I always go to the hospital after every three months with my grandmother to take pills which she said are for my good health."* **(AGYW Survey Participant)**

This depicts non-disclosure of HIV status by guardians, which highlights the gravity of the risk of HIV transmission. The risk is particularly heightened because it is during adolescence that many girls have their first sexual encounter. The non-disclosure of HIV by parents/guardians perpetuates the stigma surrounding HIV.

***HIV status disclosure to intimate partners***

AGYW bear a considerable proportion of the burden of the HIV epidemic. Study findings revealed that they have low rates of disclosure of their HIV status to intimate partners and significant others, which raises concern, as some of the adolescents were in relationships with partners who were also not aware of their status, as indicated in figure 12 below.

**Figure 12:** Aware of partner HIV status.



Of the sampled AGYW participants who indicated being in an intimate relationship at the time of the survey, 81.3 per cent (n=54) of the AGYW in Mangwe urban did not know their partners' status, followed by Bulilima where 69.2 per cent (n=35) of the AGYW were also unaware of their partners' status. In addition, 68.2 per cent (n=15) of AGYW in Matobo urban did not know their partners' HIV status. This shows an alarming risk level for HIV transmission stemming from non-disclosure of HIV status to intimate partners.

Barriers to HIV status disclosure were discussed during FGDs with AGYW and their male counterparts, and these included the fear of rejection and isolation, as stated by an FGD participant who was quoted saying:

> *"Girls are afraid to ask their boyfriends' HIV status, for fear that he will get angry and end the relationship with you, and no one wants to be single."* **(FGD with young women, Mangwe rural)**

The AGYW also mentioned breach of confidentiality as another barrier to disclosure. One FGD participant said:

> *"People here in Maphisa do not disclose their HIV status. It's hard to disclose because if anyone knows your status, they tell other people, who will maliciously spread the news. In any case, most of the people here do not test for HIV."* **(FGD with young women, Matobo urban)**

This barrier was linked to the fear of widespread stigma and discrimination within the community, as word of one's status spreads through third party disclosure. Related to this was that some girls were concerned that they may be perceived as promiscuous if they disclosed their HIV-positive status.

### 3.4 Barriers to Accessing HIV prevention, testing and treatment services.

Since the peak of the HIV epidemic in Zimbabwe millennia ago, HIV prevention, testing and treatment services have been made increasingly accessible to the public through different avenues that include Population Services Zimbabwe, New Start Centres, local clinics and hospitals, and more recently, through community-based programmes such as DREAMS and the distribution and use of HIV self-testing kits. Although so, barriers to accessing HIV prevention, testing, and treatment services still exist, especially for AGYW. Discussions with AGYW in Matabeleland South resonated with this notion, with participants highlighting key access barriers, including unfriendly health care workers, lack of confidentiality at health facilities, fear of judgement, and peer pressure. FGD participants highlighted issues around fear, saying:

> *"People tend to go to the clinic when they become very sick because they are afraid of people finding out that they are HIV positive, so they delay going to the clinic until they are worse."* **(FGD with adolescent Boys, Mangwe Rural)**

*"It's just being afraid of other people and being laughed at..."* **(FGD with adolescent Girls, Bulilima rural)**

In Beitbridge rural, 54 per cent of female participants responded that they had not utilized HIV testing, counselling, prevention, and treatment services in the 12 months preceding the survey. Similarly, 74 per cent among male participants in Beitbridge urban reported the same. In Matobo rural, 19 per cent of female participants reported that they had not utilized HIV-related services in the 12 months before the study. Likewise, 20 per cent of male participants in Mangwe rural reported the same. In Matobo, 92 per cent of female participants reported that they had utilized HIV testing, counselling, prevention and treatment services in the 12 months preceding the survey. This indicates a significant majority of female participants in Matobo urban accessing HIV related services.

Conversely, the lowest utilisation percentage among female participants is seen in Beitbridge rural, with only 46 per cent of the AGYW reporting utilization of the services. Among male participants, the highest utilization was observed in Mangwe rural, where 81 per cent of male respondents reported utilizing the services. On the other hand, the lowest percentage of utilization among male participants was found in Beitbridge urban, with only 26 per cent of respondents reporting utilization. Major reasons for non-utilization of HIV related services included lack of confidentiality and privacy at health facilities, fear of being judged and long distances to health facilities.

The general denial by parents and guardians that adolescent girls and young women are sexually active and the belief that their daughters, sisters and/or nieces are just but children make AGYW hesitate accessing HIV related services for fear of being judged and labelled as disappointment. This also highlights poor communication by parents/caregivers, as well as community elders surrounding AGYW, regarding their relationships and their sexual health. A key informant spoke on this, saying:

*"Somebody comes in and is told about PrEP, and they decide to take it. When they get home, their parents tell them to throw those pills away because they do not accept that their children are sexually active... this is a very big problem."*
**(KII with Stakeholder, Mangwe)**

Considering the reality of HIV and AIDS that has characterised Matabeleland South as a hotspot in Zimbabwe for decades, family level communication between AGYW and parents/guardians may be pivotal in encouraging access to HIV prevention, testing and treatment services by AGYW.

Protection of privacy and confidentiality is a cornerstone of ethical healthcare practices, particularly in HIV service provision. However, findings from the study revealed that in Matabeleland South, the lack of privacy and confidentiality by some health workers in delivering HIV services has become a pressing concern. Most adolescents and young people (79.2 per cent) engaged in the study indicated that the health facilities in their communities lack privacy and confidentiality. This breach of trust not only undermines the dignity and rights of community members in seeking HIV related services, but it also hampers efforts to combat HIV and AIDS effectively. Discussions with adolescents and young people revealed that the lack of privacy and confidentiality in accessing HIV related services often deters them from seeking the services. Participants expressed concern about the potential

embarrassment of getting HIV related services at a facility where they may encounter familiar faces, such as a relative working there. FGD participants were quoted saying:

> *"We are embarrassed to go for testing... the community is small...you might go to the local clinic to get tested where your aunt works, and you test positive ... everyone will be told that you are now positive."* **(FGD with adolescent girls, Mangwe urban)**

> *"Ahhh, we don't go for testing...nurses at the hospital will tell everybody when you test positive...it's better not to know my status than to go for testing at the local hospital."* **(FGD with young women, Matobo urban)**

As a result of a lack of confidentiality by healthcare workers, AGYW are engaging in risky sexual behaviour without knowing their HIV status. This increases the risk of acquiring and transmitting HIV, which contributes to the increase in HIV incidence among AGYW. This further highlights the urgent need for healthcare providers and institutions to prioritize privacy and confidentiality when providing health care services, especially to adolescents and young people.

Moreover, the use of colour coded cards to differentiate between high and low viral loads among HIV-positive patients in Matabeleland South deters AGYW from seeking HIV testing services, as they misconstrue the meaning of these cards. An FGD participant had this to say:

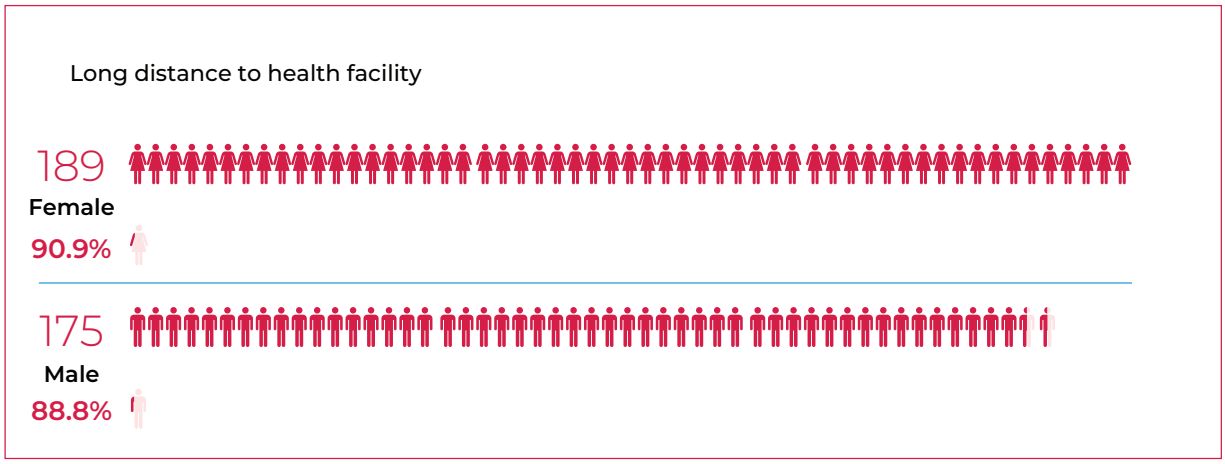
> *"There are cards that we are given when we go for HIV testing. If you test negative, you are given a yellow card, and if you test positive, you are given a green card. So it's easy for people to know your status. It's so embarrassing."* **(FGD with young women, Matobo Urban)**

While this participant was ill-informed on the purpose of the cards – as the cards are used to indicate high or low viral load in HIV-positive individuals, the same cards perpetuate stigmatization and fuel misinformation, as evidenced in the quote above. This practice undermines the fundamental principles of confidentiality and privacy in HIV service provision. It not only violates the rights of individuals to keep their HIV status and viral load level confidential but also perpetuates stigma and discrimination. The coloured cards create a visible distinction that others can easily recognise, potentially leading to unintended disclosure, social exclusion, and emotional distress for AGYW.

In addition, findings from the study revealed that some local clinics do not offer youth friendly services, which in turn reduces AGYW commitment to seeking HIV related services. Discussions with adolescents and young people revealed that most healthcare providers often scold them when they seek HIV and STI related services. When healthcare providers scold or reprimand AGYW who seek these services, it creates a negative and discouraging environment, as this kind of interaction leads to AGYW feeling ashamed and judged, which significantly diminishes AGYW's willingness to seek HIV related services.

Findings from sampled survey participants showed that more girls (58.7 per cent) than boys (22.2 per cent) were tested in the last 3 months preceding the study. This is because of AGYW, who seek services at local clinics for antenatal care. However, several factors contribute to the low uptake of HIV testing services, hindering efforts to control the spread of the virus and ensure the well-being of affected individuals. In the expansive and diverse landscape of Matabeleland South, a region brimming with cultural richness and vibrant communities, there exists an alarming disparity in the uptake of HIV testing services among AGYW. This disparity not only reflects the complex socio-cultural fabric of the region but also highlights significant challenges in combating the HIV epidemic effectively. One of the primary obstacles hindering the widespread uptake of HIV testing services is the long distances AGYW travel to access testing facilities. These findings were in line with the quantitative data where the majority of female (90.9 per cent) and male participants (88.8 per cent) indicated that they do not access HIV testing services due to long distances to the facilities as shown in Figure 15 below.

**Figure 13:** Distance to the health facility.




This was particularly highlighted by study participants in rural sites who seek services in urban centers. In addition to the long distances, the roads to the health facilities, particularly in rural areas, were found to be bad and dangerous for an adolescent girl to travel alone.

Furthermore, the lack of privacy and anonymity in accessing testing facilities adds another layer of complexity. Consequently, sexually active adolescents and young people find themselves in a dilemma where they prefer not to get tested than to get tested and have their status publicly disclosed, which increases the risk of new HIV infections among AGYW. This reluctance stems from multifaceted fears and misconceptions surrounding HIV and its implications.

Discussions with AGYW and their male counterparts indicated that they also worry about being isolated and mistreated by the community because of their HIV status. Most adolescents and young people (88.5 per cent; n=184 of female participants and 79.2 per cent; n =156 of male participants) indicated that they fear being judged, as shown in Figure 16 below.

**Figure 14:** Adolescents and youths fear being judged.


**AGYW fear being judged** **AGYM fear being judged**

AGYW indicated that they feel ashamed or embarrassed about getting tested for HIV. Hence, their hesitation to get tested. Findings from the discussions also alluded to the fact that some adolescent boys and young men would rather not know their status if they feel healthy and their appearance is unaffected. This fear is not only about testing positive but also about how others might treat them if they find out that they are HIV positive.

Other key barriers to accessing HIV prevention, testing and treatment services were found to be a lack of information on policy changes. According to the Government's SDG Mid-Year Review Report of 2023, the National Health Strategy stipulates that sexual and reproductive health (SRH) services and information must be readily available to adolescents aged 15 years and above. However, sexual debut for adolescent girls in Matabeleland South is as low as 10 years, leaving a gap between the age of AGYW who can access SRH information and services (15 years and above) and those who cannot (10 to 14 years).

When asked if they had ever utilized HIV testing, counselling, prevention and treatment services within their communities in the 12 months preceding the survey, 65.4 per cent of female and 89.3 per cent of male participants aged 15-16 indicated that they had not, while 34.6 per cent of female and 10.7 per cent of male participants within the same age group indicated that they had accessed the services. Although some adolescents aged 15-16 indicated accessing HIV related services at their local health facilities, the majority, 89 per cent, do not. Poor health seeking behaviour amongst male and female adolescents, therefore, contribute to an increased risk of HIV infection, especially considering that this same demographic is sexually active and engages in transactional and intergenerational sex.

As a result of limited access to youth-friendly services, lack of privacy and confidentiality, and negative experiences within the healthcare system, adolescents and young people are increasingly turning to unconventional healthcare options, such as herbal remedies and traditional healers. The seeking of alternative healthcare by adolescents and young people is driven by the desire for privacy, cultural beliefs, and a perceived sense of understanding and acceptance from traditional healers. However, relying solely on these unconventional options poses risks, as the efficacy and safety of herbal remedies and traditional healing practices concerning HIV prevention, testing, and treatment may not be guaranteed. Thus, the breach of trust caused by the lack of privacy and confidentiality by healthcare workers erodes the dignity and rights of adolescents and young people, fosters stigma and discrimination, and hampers efforts to effectively combat HIV infection in Matabeleland South.

### 3.4.1 Gender Inequality and SGBV

Gender inequality is one of the factors that drive HIV infections in Matabeleland South province and manifests itself through gender-based violence, social expectations about how AGYW and men should behave, restrictions on access to services and unequal access to education, among others. There are strong patriarchal tendencies and gender roles that encourage AGYW to be passive when dealing with men, and that makes it impossible for married young women to make basic household decisions. One stakeholder in Matobo district was quoted saying:

> "*For a woman to kill a hen for relish, she has to first call her husband in South Africa to give the permission.*" **(KII with Stakeholder Matobo)**

It was further reported that men make all decisions, including those that have to do with the AGYW's sexual and reproductive health. In Matobo district, all sexual activities are culturally considered as top secrets not to be talked about, which is referred to as '*Tsumbika',* and this allows sexual abuse cases to go unreported.

Gender-based violence is both a cause and consequence of HIV, impacting HIV clinical outcomes, including treatment adherence and retention, posing a significant barrier to the achievement of HIV incidence control in Matabeleland South. Research findings revealed that AGYW with abusive sexual partners had limited power to negotiate for safe sex or to access sexual and reproductive health services, including contraception and HIV-related services. This was revealed by a study participant who said:

> *"Yes, men don't care about a girl `s age. They are forced to have sex without protection; an older man may force you and tell you I was given to you by your mother, so I can do whatever I want with you. They don't even go for testing, and they don't even protect."* **(FGD with adolescent girls, Beitbridge rural)**

In addition to being gang raped, as earlier discussed, AGYWs experience physical abuse and other forms of sexual abuse by blessers and sugar daddies, and some of the AGYW's intimate partners threaten to take their lives. Some AGYW were quoted saying:

> *"Most of the Thrombozas, who assist people in crossing the border post illegally, are also our blessers. They are usually in DJ MRECKS shows. They entice young girls with money, and if you refuse to have sex with them, they beat you up and even pull a matchet out to scare you.*" **(FGD with young women Beitbridge rural)**

> *"...your husband can just tell you that I make the rules here, so whether he is coming from another woman or not, you are not supposed to ask because if you do, you will be beaten."* **(FGD with young women, Matobo urban)**

Unfortunately, the affected AGYW hardly seek services following the violence for fear of stigma and discrimination and fear of losing the sugar daddy or blesser. The full extent of abuse against AGYW is not recorded since most of it is not reported, as was confirmed by an FGD participant who said:

> *"No, we do not report the violence to the police. How can you report a man who supports you financially? You just wait for him to apologize, then continue dating."* **(FGD with adolescent girls, Beitbridge rural)**

This shows how gender inequality can lead to sexual coercion, lack of control over sexual decisions, and unequal power dynamics within relationships, with men often having more control over decisions about sexual behavior, all of which increase the risk of HIV infections. In addition, the power imbalances and social norms that contribute to gender inequality also make it more difficult for women to make decisions related to their health and to protect themselves from HIV infection.

Research findings reflect that AGYW in early and child marriages are more likely to experience intimate partner violence due to their age gap, which further increases their risk of HIV infection. This is supported by Kidman (2017), whose research showed that AGYW experiencing intimate partner violence (IPV) are at higher risk of contracting sexually transmitted infections (STIs), including HIV, compared to women not experiencing IPV.[22] IPV can lead to physical trauma, which may increase the likelihood of exposure to HIV during sexual encounters, especially where AGYW with abusive partners may be afraid to seek HIV testing due to fear of retaliation from their abusive partners.

### 3.4.2 Key Populations

Same-sex sexual activity is prohibited under Zimbabwe's Criminal Law Act of 2006, which criminalizes acts of 'sodomy' and the Zimbabwe Constitution, article 78 (3) provides that "persons of the same sex are prohibited from marrying each other". Discussions with key informants showed that key populations are unacceptable in communities across all the districts that were visited.

Men who have sex with men (MSM) experience stigma and discrimination, leading to most of them not disclosing their sexual orientation. Their experiences of stigma extend to the health care settings which hinders their access to critical HIV testing, treatment and care services. One key informant said,

> *"It's difficult for a boy to present his STI signs and symptoms in the anus as this would reveal his sexual orientation."* **(KII with stakeholder Mangwe rural)**

In addition, when key populations gather courage to go and seek HIV prevention and treatment services, public service providers reported that they would not provide services to this population group because it is illegal. Same sex relationships were also reported to be rampant in Matabeleland South prisons, but the related sexual activities are done in secrecy. Two young women were reported to have gotten married soon after they were released from prison and that is when it became known that they were gay people. Key informants were quoted saying,

22 Kidman R. 2017. "Child Marriage and Intimate Partner Violence: A Comparative Study of 34 Countries." *International Journal of Epidemiology* 46(2), Pp. 662–675.

*"It's very difficult to identify same sex couples because two individuals who would have consented to have such an affair will not do it in public but once we identify them, we send them to the police."* **(KII with stakeholders, Plumtree)**

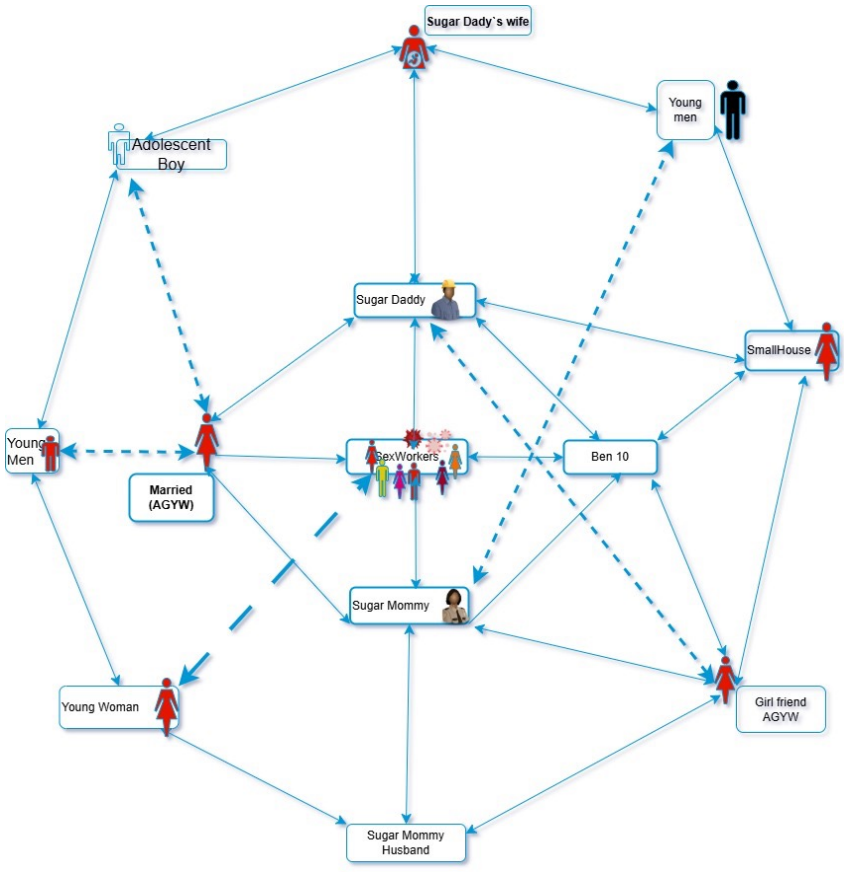
*"The law of Zimbabwe does not permit homosexuality. So, once the law does not permit, it becomes difficult for us to offer services to these people, we cannot offer those services."* **(KII with stakeholder, Plumtree)**

A combination of the secrecy of sexual activities and not going for HIV prevention services such as HIV testing and STI management, inconsistent and none use of condoms, increases AGYW's risk of HIV infections, thus keeping the HIV incidence in Matabeleland South high.

### 3.4.3 Web of Sexual relationships

The multi-dimensional nature of the sexual relationships portrayed in the research data, as discussed in the section on *Factors Contributing to High HIV Incidence Among AGYW in Matabeleland South*, highlights a complex network of sexual relationships in the province, as illustrated in figure 17 below.

**Figure 15:** Web of sexual relationships.



As illustrated in figure 18 above, sex workers engage in sexual activities with different partners, including married men, young men, and even adolescent boys. These same sex workers' clients also have sexual relationships with AGYW. The web extends further to include sexual relationships between adolescent boys and young men and sugar mommies, while adolescent girls engage in sexual relationships with blessers/sugar daddies. The complexity of these sexual relationships, paired with the factors discussed earlier in this report, contribute to high HIV incidence among the larger population of Matabeleland South, especially among AGYW.

## 3.5 HIV Programmes in Matabeleland South

HIV prevention programs that aim to stop the transmission of HIV play a crucial role in addressing HIV incidence. The study revealed that there are various development programmes responding to high HIV incidence among AGYW in Matabeleland South province. Some of the partners implementing these programmes included the Determinant Resilience Empowered AIDS-Free Mentored and Safe (DREAMS) consortium, Zimbabwe Health Intervention (ZHI), Campaign For Female Education (CAMFED), Hope For A Child In Christ (HOCIC), Zvandiri, Organisation For Public Health Interventions and Development (OPHID) among others. However, despite efforts by these partners to combat HIV, HIV infections continue to increase among adolescent girls and young women in Matabeleland South Province.

One major challenge in ongoing programming efforts was reported to be ineffective program targeting, whereby programmes do not target the right population groups, which, if targeted, would result in a significant positive change in AGYW's HIV incidence. One key informant was quoted saying:

> *"I think we have a challenge with programme targeting because some programs should be targeting community leaders for dialogue and not just pass through to greet them at the beginning of a project."* **(KII with stakeholder Mangwe)**

Using community leaders as a stepping stone for programme entry into a community and disregarding the pivotal role they play in spearheading change of harmful socio-cultural norms, practices, and beliefs draws back the efforts by NGOs and CSOs to reduce HIV incidence, particularly in Matabeleland South.

According to the 2017 UNAIDS Joint United Nations Programme on HIV and AIDS, HIV among AGYW aged 15-24 is 44 per cent higher than that of their male counterparts. While focusing HIV programming on AGYW is warranted, the little to no male inclusion in related interventions has widened the knowledge gap between the two sexes. This has subsequently suppressed the extent of positive programming results in reducing HIV incidence among AGYW in Matabeleland South. Furthermore, the patriarchal nature of the communities that places men in positions of authority over women again suppresses the power that AGYW have to negotiate for safe sex, refuse unwanted sexual advances and reduce their risk of contracting HIV. Sampled adolescents and young people were asked if they had been tested in the 3 months preceding the quantitative survey, and their responses are summarised in table 5 below.

**Table 5:** HIV Testing in the last 3 months.

| | NO | YES |
|---|---|---|
| Adolescent Girls & Young Women | 34.8% (n=86) | 72.6% (n=122) |
| Adolescent Boys & Young Men | 65.2% (n=161) | 27.4% (n=46) |

The statistics presented in table 5 above highlight poor HIV testing practices amongst adolescents and young people, more so for the male participants than the female participants. Specifically, 72.6 per cent of the sampled AGYW reported having gone for HIV testing in the 3 months preceding the study, while only 27.4 per cent of male participants indicated the same. Additionally, 81.6 per cent of male respondents indicated being sexually active, while 65.2 per cent of the male participants were not aware of their HIV status. Considering that these adolescent boys and young men have sexual relations with AGYW and sugar mummies, non-awareness of their HIV status contributes to the high HIV incidence in Matabeleland South, particularly among AGYW.

Qualitative enquiry revealed the perceptions of adolescent boys and young men on being left out in HIV programmes within their localities when they said:

> *"We have never seen programs which come to teach boys here in Plumtree about HIV and how we can protect ourselves from it."* **(FGD with Young Men, Plumtree rural)**

> *"There are no programs or projects that teach boys about prevention, testing and treatment of HIV; you are the first for me."* **(FGD with Adolescent Boys, Bulilima Urban)**

This further highlights the extent to which adolescent boys and young men have not been benefiting from HIV programmes. The HIV programmes available in Matabeleland South, such as the DREAMS and Sista2Sista programmes, place much emphasis on AGYW, with training and information dissemination being provided on HIV transmission, prevention, testing and treatment – all of which are aspects that adolescent boys and young men miss out on. AGYW also attested to this saying:

> *"Most of these programs target girls...so when you tell your boyfriend about these things, he will be clueless because the programs are only attended by the girls, like DREAMS or Sista2Sista."* **(FGD with Young Women, Mangwe Rural)**

Although most HIV programmes work primarily with AGYW, some programmes work with both male and female adolescents and youth, such as Zvandiri. While Zvandiri also targets adolescent boys and young men in its programming, its focus on HIV-positive individuals makes it an avenue for stigmatization. FGDs with adolescent boys and young men revealed this reality when participants said:

> *"There is this other program called Zvandiri that concentrates on boys. Most guys used to go there, but it then became difficult for others as most people started thinking that if you are going to Zvandiri, then it means you are HIV positive."*
> **(FGD with adolescent boys, Matobo urban)**

The limited focus on adolescent boys and young men in HIV testing, prevention and treatment interventions in Matabeleland South could directly and negatively influence the high HIV incidence not only amongst AGYW but across population groups in the province. Reflecting on the factors discussed earlier in the report, such as intergenerational and transactional sex, child marriage and gender inequality, are not only perpetuated by one demographic group but rather, by a mix of groups that include adolescent boys and young men, older men, parents and/or guardians, sex workers, men and women in formal and informal employment, for example in road construction and public service, as well as truck drivers. Therefore, this highlights the need for a comprehensive approach to HIV programming to positively effect a decrease in HIV incidence among AGYW and the province at large.

In addition to targeting the right population groups in programming, targeting the major factors that contribute to high HIV incidence in the province is critical. Study findings showed that programmers focus more on project performance targets, such as reaching 104 per cent of the expected targets, rather than on the lives of the individuals the project intends to transform. This was echoed by a stakeholder who said:

> *"But then when officers are in the field, they prioritise meeting deadlines and targets... You find that someone will be running in this direction, and another in that direction because those targets are linked to their salaries, benefits, and livelihoods. Programmes do not move with the human beings they are supposed to support... they just chase their targets."* **(KII with stakeholder, Mangwe)**

With regards to targeting key factors that contribute to HIV incidence, one example is that despite the limited and, in some instances, lack of knowledge of HIV among AGYW, none of the NGOs engaged indicated that they use the comprehensive sexuality education (CSE) curriculum. The study revealed that insufficient comprehensive sexuality education and lack of awareness about safe sexual practices among AGYW are significant impediments in the fight against HIV in the province.

Discussions with programme partners revealed that there is a tendency for siloed programming, with some organizations focusing solely on HIV while others focus on sexual and reproductive health. Some exceptions, such as the DREAMS project, use a layered approach whereby members of the DREAMS consortium address HIV, SRH or both. Integrating HIV as an integral component of sexual and reproductive health could help to address stigma and discrimination, which deter certain population groups, including adolescents and youth, from accessing HIV prevention services. If programmes do not proactively address issues of stigma and discrimination, young people will continue to avoid being tested and disclosing their status.

While HIV prevention programmes in Matabeleland South are trying to address gender inequality by targeting AGYW in their programming, the underlying socio-cultural causes of gender inequality, including negative masculinity and patriarchal attitudes, as well as harmful cultural practices, continue to be some of the leading causes of HIV infections among AGYW. Gender inequality limits AGYW's ability to make decisions about their health. They have limited power to negotiate for safe sex or access sexual and reproductive health services, including contraception and HIV testing, which are the services offered by the different programmes in Matabeleland South province. A key informant revealed this saying:

> *"As a result of gender inequality, young women don't have the power to say anything to a man. Right now, a man will go to the bar, be with other girls, then come home at 1 am and then have unprotected sex with his wife. The wife cannot deny it because it's her husband."* **(KII with stakeholder, Matobo)**

> *"Here, we have some cultural practices that could also be causing HIV infections. For example, the father-in-law is the first to have sex with his daughter-in-law on her first night in her marital home."* **(KII with stakeholder, Beitbridge)**

In adherence to the legal age of consent, HIV prevention programmes in Matabeleland South do not include in their programmes, adolescents aged 15 years and below, as confirmed by a stakeholder who said:

> *"...we target AGYW between the age of 15 and 24, and we give them our comprehensive sexual education and life skills."* **(KII with stakeholder, Umzingwane)**

However, many adolescents 15 years and below are sexually active, with one stakeholder reporting that the youngest mother in Matobo at the time of the study was 9 years old. These sexually active under 15 adolescents are deprived of HIV information and prevention services that include PrEP, PEP, HIV testing and condom use, among others. One observation from the field visits was that many adolescent girls were already mothers, especially in Mangwe, where they reported that they had deliberately got pregnant so that they could access sexual and reproductive health services without being interrogated by health workers about their age. This presents a structural barrier to accessing SRHR services for minors, which negatively implicates their sexual behaviors and, subsequently, their high fertility and increased risk of contracting HIV. This is particularly because of their need to become independent of their parents/caregivers by becoming mothers themselves and being better able to access SRHR services autonomously without fear of scrutiny by members of their respective families and/or communities.

# 4 SECTION IV. CONCLUSION

In conclusion, the factors that contribute to high HIV incidence among AGYW shed light on the complex landscape of HIV prevention and treatment efforts in Matabeleland South. These HIV risk factors constitute a complex web of sexual relationships which increase HIV incidence not only among AGYW but among the provincial population at large. These challenges are deeply intertwined with cultural, socio-economic, and gender-related factors, which underscore the need for a multifaceted and holistic approach to combating the HIV epidemic in the province.

The barriers to accessing HIV testing services, such as geographical distances, lack of privacy, and fear of stigma, highlight the importance of addressing structural and systemic issues that impede access to HIV services. Additionally, gender inequality and sexual gender-based violence (SGBV) exacerbate the vulnerability of AGYW to HIV infection, emphasizing the necessity of addressing power imbalances and harmful cultural practices that perpetuate these inequalities. Furthermore, the exclusion of adolescent boys and young men from targeted interventions, along with fragmented approaches and ineffective targeting, aggravate vulnerabilities among AGYW. The lack of integration between HIV programming and SRHR perpetuates stigma and discrimination, further impeding access to essential services. Addressing these systemic issues is critical for achieving meaningful progress in reducing HIV incidence in the province.

Therefore, the intricate interplay of several factors contributing to high HIV incidence among AGYW underscores the urgent need for comprehensive, context-specific approaches to HIV prevention and treatment in Matabeleland South. Overcoming the structural, cultural, and gender-related barriers to accessing HIV services is essential for achieving sustainable progress in reducing HIV incidence and improving the health and well-being of all individuals in the province. Understanding and addressing these complexities is vital for shaping effective strategies that can make a lasting impact on the HIV epidemic in Matabeleland South.

# 5 SECTION V. RECOMMENDATIONS

1. **Establish Social Safety Nets for AGYW from underprivileged families through the provision of conditional cash transfers that can be instrumental in helping AGYW meet their basic needs and reduce their reliance on child or early marriage, transactional sex and/or sex work.**

   Designed primarily to alleviate economic hardship, cash transfers allow for vulnerable populations, such as AGYW from underprivileged families or child-headed families, to gain much needed financial support and ultimately reduce their economic vulnerability. To qualify for the cash transfer disbursements, beneficiaries can be given targets around safer sex practices and health seeking behaviour or testing negative for sexually transmitted infections (STIs).

2. **Strengthen the provision of vocational skills training opportunities to adolescent girls and young women to increase their earning potential and overall economic independence.**

   Providing AGYW with vocational skills training and support is a sustainable approach that directly improves their long-term economic empowerment and independence that may deter them from engaging in sex work, transactional and/or intergenerational sex. Being able to independently sustain themselves financially through economic activities will, in turn, increase AGYWs negotiation power for safe sex, the power to refuse unwanted sexual advances and to be proactive in circumstances of abuse.

3. **Design family level income generating activities to boost parents' financial capacity to provide holistic care for their children and youth.**

   Family level income generating activities provide sustainable family level economic empowerment that can be sustained over time and whose benefits can be life changing, not only for the AGYW but for the family. This is particularly key for reducing early and child marriages that have been driven by poverty and lack of economic empowerment.

4. **Design and implement programmes that empower men and boys to understand SRH and HIV better and increase their related service uptake.**

   Involving men and boys in SRH and HIV programs helps challenge harmful gender norms, promote gender equality, and foster healthier relationships. This further promotes positive health seeking behaviours and improved comprehensive understanding of SRH and HIV.

5. **Foster partnerships with community-based organizations, traditional and religious leaders, and other stakeholders to challenge harmful gender norms and promote gender equality, as well as engage men and boys as allies in addressing SGBV and promoting positive masculinity.**

   This harnesses collective efforts to challenge harmful gender norms, leading to more comprehensive and sustainable solutions. This approach ensures that interventions are culturally sensitive, effectively reaching and positively impacting the communities most affected by SGBV and gender inequality.

6. **Partner with youth-led organisations to expand HIV prevention services and reach vulnerable populations in Matabeleland South.**

   Partnering with youth-led organisations leverages the unique perspectives, creativity, and understanding of local dynamics that youth-led organizations possess. It fosters ownership and sustainability of HIV prevention efforts, thus empowering adolescents and young people to take charge of their health.

7. **Provide a mix of edutainment including working with influential artists, to impart HIV information to young people.**

   Young people are more likely to engage with and retain information when entertaining and engaging. The impact may be great when the message is delivered in a relatable way and through popular artists.

8. **Establish youth hubs/centres that allow for supportive community environments that provide alternatives to negative role models and behaviours.**

   Youth centres provide safe spaces for young people, giving them privacy and addressing their fears of stigma and discrimination as a wide range of SRH and HIV information and services can be provided at the centre, including HIV testing and counselling complemented by a variety of recreational activities.

9. **Develop and implement peer pressure strategies that promote positive peer influence against drug and substance abuse, including the establishment of positive peer networks early in adolescence.**

   This approach targets young adolescents while they are still impressionable to help them resist peer and media pressure to engage in drug and substance use. Engaging them at a formative stage prevents them from succumbing to such influences and promotes healthier lifestyle choices well into the future.

10. **As a follow-up to this study, conduct case studies on some of the emerging factors, e.g., artisanal miners and large population movements at border towns, to provide more information to programmers working to reduce HIV incidence amongst AGYW.**

    Developing case studies will be instrumental in identifying and understanding the root causes that perpetuate HIV incidence amongst AGYW and will facilitate the design and implementation of multi-dimensional interventions that target relevant parties such as private and public sector players and communities, etc.

    N.B: Details of recommendations are in the recommendation report.

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